Robert Burke 1-75

MARCH 1958

THE DRIVE FOR ACQUISITION

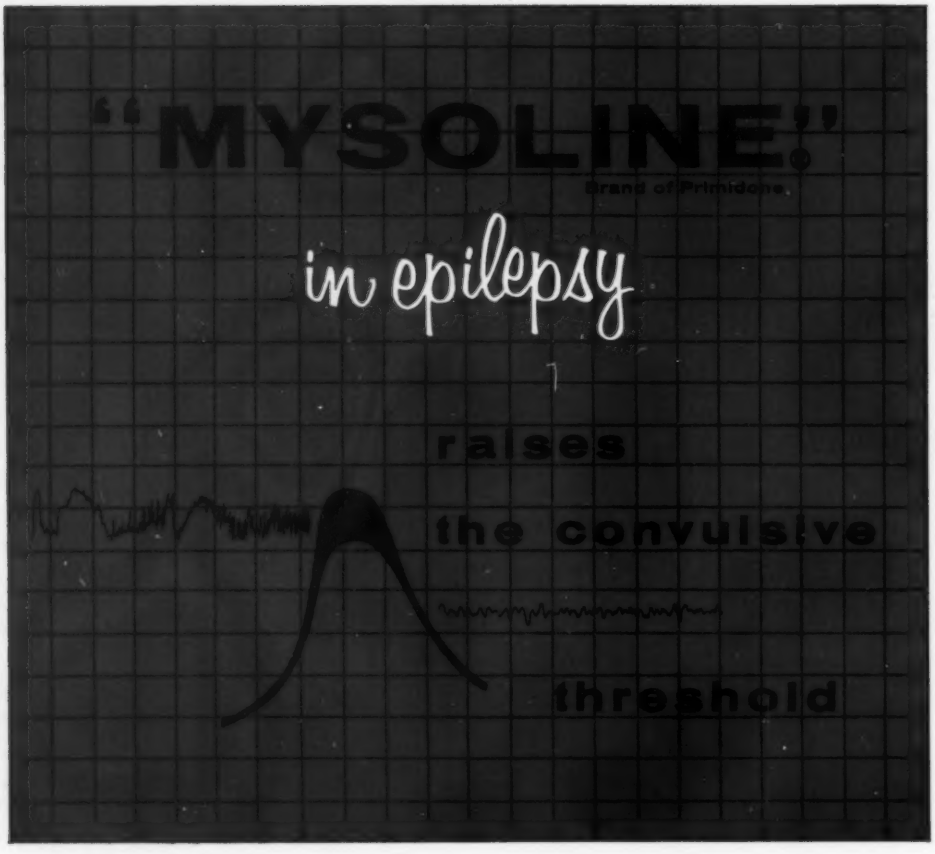
THE DRIVE FOR INTEGRITY

MANAGEMENT AND
THE BUSINESS ADMINISTRATOR

REPORT ON THE FIRST
MENTAL HOSPITAL DESIGN CLINIC

Mental Hospitals

American Psychiatric Association



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Mental Hospitals

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THIS MONTH'S COVER

Photo: Dr. Mary V. Jackson, Chairman of the Planning Committee for the First Canadian Mental Hospital Institute, is shown flanked by admiring V.I.P.'s who contributed to the program. Left to right are Dr. Daniel Blain, A.P.A., Medical Director; Hon. Walter S. Maclay, MD., C.B., O.B.E., of Britain's Ministry of Health, who delivered the Academic Lecture; Dr. Jackson; Dr. G. E. Hobbs, President of the C.P.A.; and Dr. Harry C. Solomon, A.P.A. President.

The first Canadian Institute, which was held in Toronto January 20th through 24th, was characterized by active participation, high quality leadership and the implicit recognition that, because the patient is a person of dignity and worth, all therapeutic efforts should be directed to maintaining and reinforcing this precept.

In addition to those registering at the Institute—approximately 135 senior psychiatrists mostly from Canada, but with representation from the United States—each session was attended by local representatives from ancillary groups. From 100 to 150 people attended each session.

Each discussion leader presented his topic in a clear and provocative manner which stimulated lively discussion from the floor. In addition to the leader and chairman, an average of thirteen discussants took part in each session, with twenty-one the highest number participating in any one meeting.

The atmosphere throughout was characterized by enthusiastic optimism, mixed with a healthy respect for the magnitude of the problems of mental health. The over-all theme of the meeting, "The Mental Hospital in the Changing Community," emphasized a program of positive action which would benefit the patient.

There was uniform acceptance of the concept that the hospital is itself an active therapeutic community. The principle of using techniques to encourage social interaction on the wards, using open-door arrangements, day hospital facilities, etc., can provide the basis for increasing its therapeutic potential. There is a need for continuity of care for the psychiatrically disabled, and community resources—both lay and professional—should be considered as essential in the total therapeutic effort.

Particular problems of the forensic patient, of the child needing psychiatric care and of the patient addicted to drugs and alcohol were recognized as requiring special attention to determine the most effective methods of care and treatment.

The research and teaching opportunities in mental hospitals were discussed, with emphasis on the problem of obtaining financial support, how to develop the best type of organization and methods of training. Tremendous opportunity exists for the further development of research and training within the mental hospital framework.

Dr. Walter Maclay's Academic Lecture "Experiments in Mental Hospital Organization" outlined brilliantly the developments in British hospitals. It was clear that there is an upsurge of interest directed to the kind of procedures and arrangements which could favorably influence the mental patient. It is significant that in England there is great support and encouragement at governmental level, which facilitates new developments. There is a good deal of emphasis on voluntary admissions, the opening of many wards and the development of special training areas as an extension of rehabilitation services in England.

A. MILLER, M.D.
The Ontario Hospital, Toronto

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The Needs of Mental Patients

III. The Drive for Acquisition

By LEWIS B. HILL, M.D.‡

Sheppard and Enoch Pratt Hospital, Towson, Maryland

The drive to acquire possessions is observable to some extent in everyone in this culture. It may express itself (a) as a symptom, or (b) as part of a problem in logistics in an attempt to accomplish a plan or arrive at a goal, or (c) as a drive to use the possession of things as a symbol to support the needs of one's internal reality, that is, what Fenichel has called "narcissistic supplies."

As a symptom, the drive to acquire things is seen in the miser, the stamp collector, and, in the case of hospitalized mental patients, frequently as the activity of those who are without hope of improvement of their status in the world and who have lost the struggle for internal security. These patients may collect things which are worthless in the eyes of others, and perhaps even in their own eyes. This collecting habit, which is a headache for hospital management, can usually be taken as an evidence of frustration of the patient's normal need for possessions. In this sense, his having become so destitute and so futile that he devotes his energies to collecting junk may be a reflection upon the environment the hospital provides for him. To deprive him of his collection of junk is only a further insult to him. Practically, the junk must be cleared out; but the treatment of the patient requires that his normal drive be recognized by providing him with the opportunity to acquire something of recognized value.

The drive, or the necessity, to acquire materiel in order to carry on one's warfare against one's enemies is to be found in both the healthy and the sick. His mental illness does not deprive the patient of his normal ambitions and hopes. The possession of money, for instance, is a necessity for any plans he might have to leave the hospital and re-establish himself in the community. Sometimes his suspicion is such that if he comes by some money, he will hide it. The patient must also have some clothes and sometimes some tools with which to work when he seeks employment. It takes more than money, clothes and tools to establish himself in the community and he needs and seeks skills, training, and education in order to get out of the hospital, to get a job, to be independent, sometimes to be married, or to prepare for future adversities.

These are all legitimate drives and activities of patients as well as of the rest of us. However, hospitalization makes it extremely difficult to carry out these drives and to accomplish these goals. Some hospitals have a plan whereby patients, in exchange for work, acquire tokens which are negotiable in the hospital for things they desire, cigarettes and so on. This plan is reported to be eminently successful. It is an example of what can be done by a hospital to maintain the patient's ability to accomplish something to satisfy his need for independence and accomplishment, and to redeem some of the goals which he has lost because of his hospitalization.

For the purposes of internal reality, people need to acquire things, possessions, property, as symbols of accomplishment, as an expression of their individuality and in support of their self-esteem. The mental hospital environment increases the need for these symbols of significance, but at the same time it diminishes the opportunity to acquire them. Yet some of these symbols can be made available for those patients who seek them and show that they can take care of them. Before referring to some of the practical little things that are of great importance to patients. I invite you to a little theorizing.

It appears that what I call "me" or "myself" is my subjective awareness, insofar as I am aware, of all that I am. This self has the quality of a continuum of experience. In fact, it exists only at the moment, but in the present moment an essential ingredient of the self is the memory of the past and the structuring, in character, of past experience. Another essential ingredient of this self-of-this-moment is anticipation of a future, which is based on an extrapolation of past experience, generously distorted by hopes and fears. Except perhaps for rather rare moments when one feels whole and complete and in unison with the cosmos, the awareness of self is reciprocally bound up with awareness of the not-self.

Self exists in a medium of that which is not self, but which consists in significant measure of other selves who appear to be more or less like myself, and yet, if I am healthy, are not mistaken for myself. If I am not healthy or if I am immature, there is a serious problem involv-

‡ **Editor's Note:** *This article was received from Dr. Hill shortly before his sudden death on February 4, 1958.*

ing the recognition and maintenance of the boundaries of the self and between the self and others. There are many devices for maintaining boundaries. Among them is the establishment of personal and private ownership of property, of possessions and of position. Wars have been fought over boundary lines to determine who owns the oil under the desert, who owns the religion, or language, or control of the people on the land.

It is evident that what I call "me," "myself," is very difficult to reduce to a definite, limited and exact entity. If you have ever asked a number of patients to point out what they call "I" you will note that most of them can't do it. Some point to the head, a few to the chest, and some to the pelvis. Many get quite confused. This brings up the relationship which exists between "me" and "my." It is "my body," "my mind," and "my self." It becomes apparent that the term "mine" implies that the object has some of the qualities which I identify as being the qualities I have, and yet the thing I call mine is, in a sense, not me. It might be said that it ought to be me, or a part of me. It is needed in order for me to maintain my identity and self-esteem. It becomes apparent that my image of my body includes more than my anatomy. My body image naturally includes my clothing, but it does not stop there. It includes my house, my car, my office, and to a degree, my family, and my dog.

Likewise, my mind includes much of the content of my mind, such as the representation therein of my parents, and of my friends, and so on, which I have as inclusion bodies. They are mine, but not me.

Myself includes more than my body and mind. My integrity and my mental stability lean heavily on this; for example, my name is important, also my title. You may note your reaction to being called occasionally "Mr." rather than "Dr.", and your still stronger reaction to being called, "Say, you there." Furthermore, my self-esteem depends upon my signature, my ability to write a check and have it accepted. That is, my valid bank account supports my self-esteem.

Disruption Can Be Minimized

Coming back from this generalization to the concrete situation of the hospitalized patient as I have seen it, there is a tremendous diminution of the self, and self-esteem, of a patient by the very act of being admitted to the institution. Some of the things which patients have found most disruptive of their sense of an adequate self can be made less damaging by thoughtful recognition and appropriate action. Some of them are perhaps inevitable in the fact of becoming mentally ill and being hospitalized. Those which can be modified certainly should be, as part of therapy, and those which cannot be mitigated should be explained to the patient.

Because most of my experience has been with women patients and because it seems that personal possessions and personalized surroundings are more important to women, I shall give examples brought to my attention by female patients. I know, however, that male patients also have equal needs for acquisition, possession and individuality which is recognized by others.

A woman patient, admitted to the hospital, is ordinarily divested of clothes and jewelry. If we are to believe the advertisements, she is simultaneously divested of dignity, personality and pride. Married women specifically resent removal of wedding rings. This is not to say that some would not have thrown them in the toilet in a moment of rage at the husband, but it is one thing to throw the accurséd ring away, and quite another thing to be deprived of the security supported by that token of marital status. In spite of rage at their husbands, psychotic women are all too often preoccupied with fear of desertion and divorce. Their suspicions that they are being railroaded into the hospital so that their husbands can seek another woman are confirmed when the ring and their personal clothing are removed.

When clothes come back, if they do, they bear marks indelibly stamped into the fabric, or sometimes labels firmly sewed on. The patient shudders at the thought of her friends at home seeing these indelible signs which shout that she has been institutionalized. No doubt it is necessary to identify personal clothing, but some method can surely be found which does not permanently brand the patient's garments.

Such is the need of the patient for possession of things to identify herself that she extends the feeling of "mine" from her assigned bed and place at the table to at least one or two of her neighbors, patients or personnel, to her ward, and to her doctor and nurse. I have seen a patient become so disturbed that she was moved to a disturbed hall because, so she later told me, her nurse had been assigned away from her to that other hall. She preferred to go backward and stay with her own nurse than go forward away from her. And I have seen the reverse, that is, a patient who pulled herself together enough to move to a convalescent hall because the night attendant or one patient friend had moved there.

Another example which impresses me is seen in occupational therapy. Mental patients are like the rest of us in most of their needs. Frequently, however, because of their illness, they are not able to fend for themselves nor fight for their own. Perhaps a majority of hospitalized patients believe that it is good policy not to show initiative and possessiveness, which might be called selfishness. One may suppose that occupational therapy is a good thing. Making anything useful or beautiful is good for the patient, but it is possible for the patient to accept the whole program as one more evidence of regimentation and loss of individuality. I am convinced that for some patients the act of making something, weaving something, is meaningless in itself. Something is being done because someone said do it. The picture changes and the patient's attitude changes if she makes something for someone she likes or feels she can help. And the attitude of many patients improves still more if they are encouraged to make something for themselves. An obsessive, depressed patient may weave or knit endlessly for the hospital or some of her family whom she has no reason to love, as a bit of contemptuous ritual or as self-abasement and punishment for an unending sense of worthlessness. If she can be helped to pick her own material and color to make something for herself or for her home, the activity becomes constructive and her acquisitive drives are mobilized to help in recovery.

In my observation, most of the things women generally need are also desperately needed by mental patients. Examples of women's needs are endless, as any man knows. They are her own toilet articles, cigarettes, trinkets, letters and little luxuries. These are all essential in asserting her own selfhood. I would here mention a place to keep these things, private and safe. In addition, the possession of a potted plant or a plot of garden, or the responsibility for arranging flowers in a part of the hospital can make the difference between imprisonment and living in a therapeutic community.

Women patients frequently complain that they are not permitted to wash their own hair. I have noticed, not infrequently, patients with a new hairdo which did not particularly become them or express their own personality, and I learned that it was chosen by the hospital beautician or nurse. Sometimes steps to induce all concerned to let the patient select her own style will diminish her frustrated hostility and increase her sense that she is still a person with a life to live.

There are a number of patients, as there are normal persons, who are neither followers nor leaders. They are individualists. Some of them are happy and secure with their little corner of the workshop or with their own little tasks—such as raising the flag each morning, or helping to sort out the hall supplies. These acts and responsibilities are, for these patients; acquisitions—vested rights which they value.

Recently I read with satisfaction of a hospital in which there are washing machines and ironing boards for patients who want to launder their own things. I regret that there are still hospitals in which the patient has no place to hang her garments when she has washed them.

When in Worcester we opened a cafeteria for patients, I recall particularly the delight many expressed that now they could choose their own dessert and vegetables, and their own table with their own friends. We also noticed that when patients of the two sexes ate in the same room, the men became interested in neckties, haircuts and shoeshines, and the women tore strips from the curtains in order to make garters to keep up their stockings. Those little things which indicate the sex of the patient and some pride in being a member of that sex are acquisitions of great value, not only to make life tolerable in the hospital but to make it seem possible for the patient to make the struggle to get out of the hospital.

I would like to return for a moment to acquisitions of objective value. Insofar as the hospital is a therapeutic experience, it functions both to heal old wounds and to open the way for new adventures in living. It is a dreary business counting the days and months, wondering if one is getting better. Patients wonder and doubt because in the process of getting better they often feel worse. The bitter timelessness of illness can be somewhat neutralized by opportunity and encouragement to acquire and possess new information, experience, skill and interest in things. One woman, who had never been allowed by her mother to do anything in the kitchen, was lifted out of her sense of futility by being allowed to help in the kitchen where she learned to prepare food for cooking. Another woman discovered how to grow plants from seeds and tend her own garden when she went home. There was another who found that she could design and make a dress for herself.

As a summary of what I have been trying to say about the drive for acquisition as an innate force toward recovery, it is true that many mental patients, by virtue of inherent attitudes and training, have limited themselves severely in their ability to have and use the good things of life for security, satisfaction and self-realization. Any whole treatment of these patients must include opportunities, incentive and encouragement to get and use things of which they have been deprived. Such new acquisition of things, interests and skills is not only therapeutic, but helps prevent relapse; it not only ameliorates difficulties, but produces growth toward health.

There are patients who apparently have plenty of everything they could want and yet they become ill. In the treatment of these patients it is important that we strive to enable them to keep their assets. It is ironic to recover from illness only to find that most of the things by and for which one lived have lost their value or have themselves been lost.

Attention to the need for acquisition is therapeutic for the sick, and productive and conservative of the healthy aspects of the patient.

IV. The Drive for Integrity

By SOL W. GINSBURG, M.D.

New York, New York

As I read Dr. Barton's challenging and comprehensive outline of the "needs of mental patients", I was in quite familiar territory until I came to "Drive for Integrity", the category on which I had been asked to comment. The majority of the "needs" enumerated by Barton—oxygen, food, sex, etc—ranged from those required for the maintenance of life itself to those which are generally accepted as essential to mental and emotional well-being. They are basic human needs shared by all.

But "integrity", as a word and concept, is not often encouraged in psychiatric parlance. However, on further reflection it, too, became assuringly obvious: of course, everything we do for and with a patient demands the highest regard for his integrity. But the word itself con-

tinued to seem strange in this context, and just to check my impression, though clearly without any presumption that such a check could be definitive, I glanced through a dozen or so familiar books on psychiatry without finding any explicit reference to "integrity" in discussions of patients' needs. In fact, the whole concept that the patient has needs is rarely discussed with the direct, forthright approach used by Barton, and we must be grateful to him for the emphasis contained in his paper.

The dictionary defines "integrity" as "wholeness; the state or quality of being entire and complete". In that sense, everything we do for another person, friend or patient, colleague or loved one, which strengthens his sense of wholeness also satisfies his need or drive for integrity. Other words come quickly to mind in this connection—dignity, self-regard, self-worth—and if we add them together we have a peculiarly apposite definition of our goal for our patients: to make the sick person again "whole". It is not often that a definition derived from "ordinary" life is so clearly appropriate in a technical sense. When we change the words a bit and use such terms as ego strengths, ego integrity, identity, capacity for growth and adaptation, we are for the most part dealing with the same concepts and goals in the management and treatment of our patients.

It is especially appropriate to consider this particular need (integrity) at a time when there is much discussion of the so-called open hospital and many attempts to implement this program, both here and abroad. I certainly do not need to interpret "open hospitals" to this audience, but the more I consider the matter of helping our patients achieve a feeling of integrity, the more apparent it becomes that this stands at the very core of the open hospital program.

After all, the concept of an open mental hospital, especially the large, public mental hospital, does not envisage any radical (or other) change in the psychotherapeutic approach which is generally considered the basic element in treatment of the mentally ill; it does not require us even to reconsider our attitudes, pro or con, toward the pharmacological and physiological modes of therapy in current use, such as drugs, shock therapies, etc.* Its whole emphasis is dramatically on the patient as a person and on the ways in which he is treated as a human; fundamentally on his behavior as a person in a hospital community which is an integral part of a larger community and on his relationships with the others—doctors, staff and fellow patients. And, after all, these are of the essence of our concern for his integrity.

What, then, are some of the changes contemplated in the open hospital and how do they illustrate this thesis?

The first liberty envisaged for the patient is the freedom to come and go, the absence of restraint, either mechanical, pharmacological or other. In 1905, George Zeller, one of the generally unrecognized group of American pioneers in what we now call the open hospital movement, had entirely abolished restraint of any kind in his hospital (Illinois Asylum for the Incurable Insane, later the Peoria State Hospital), and had placed at the head of his instructions to his staff the injunction: "Mechanical restraint will never, under any circumstances, be applied to any inmate. Inmates may not be imprisoned and secluded. *It requires an antagonist to provoke a quarrel* (my emphasis); hence when inmates are unruly they should be soothed by gentle words and a gentle manner."

There is a pleasantly archaic flavor to the language of this order but the sentiments and the admonition they contain are brilliantly contemporary. Of all the indignities and pain inflicted on mental patients, even if presumably "for their own good", restraint and its corollary, seclusion, have always seemed to me the worst. These are the devices that bring the sick closest to the status of caged animals, the absolute antithesis of integrity as human beings.

Practical Reforms Bring Therapeutic Gains

Another great invasion of the patient's sense of integrity occurs in the disregard of his privacy, one of humanity's most cherished privileges and rights. This occurs in a variety of ways, all destructive to his sense of wholeness. Ordinarily, toilet practices and facilities would not come to one's mind in this connection and yet a bit of reflection will clarify the validity of emphasizing them. The lack of screened, closed toilets not only robs the patient of a sense of decency and wholeness, but also encourages his regression to earlier childish patterns of thought, interest and behavior in his toilet habits. Here, as elsewhere, reform of traditional practices, that begins properly as a concern for the patient's integrity, carries with it the promise of great therapeutic gains as well, since the more one respects his needs in these regards, the more adult and disciplined in general will be his response to the challenge and the opportunity.

Some of these elements pertaining to the patient's privacy and integrity were emphasized for me early in my work in psychiatry. I recall vividly a patient we had at a small psychiatric hospital where I worked some thirty years ago. She was a woman of about 50, completely mute, her conversations limited to mere grunts, usually of disapproval and hostility. I learned a lesson of respect for the patient's integrity from Bernard Glueck, my chief. This included the admonition that I must talk *with* her as though she were indeed responding in words, must try to understand her grunts and squeals and never condescend in my comments to her. It also included the warning that I must always respect her privacy and person. Never was I, or anyone, to enter her room without the usual courtesy of knocking on her door and waiting for her nurse to respond; her hair, nails, etc., were to be carefully groomed; her food served on an attractive tray, etc., etc. All this despite her complete inability to communicate in words at all; perhaps it was especially important because of this.

Recently, as I was going through a new hospital, I

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* *This is, of course, a vast oversimplification which I have allowed myself only because of the emphasis of this paper. There are many unresolved questions as to these and other aspects of the open hospital—matters of staffing, of emphasis in the therapeutic regime, of the vital community aspects of the program—of all of which I am aware but consciously put aside for the moment.*

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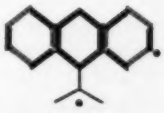

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asked a patient, who had spent much time in a variety of institutions, how he liked the new place. He chose the following to illustrate his approval: a locker, completely private, for his possessions; a place where he could sit and write a letter in comfort; and a real, honest-to-goodness barber shop. Oh, yes, he said, he liked his doctor and the nurses were kind, the food "pretty good", but these small "private" resources were obviously the ones he prized the most. They were in the service of his "integrity".

It is worth noting that Zeller, in 1905, seems to have anticipated this, too: "When women went about in ill-fitting dresses, shoes untied, hair uncombed and a slouchy air in general, they deteriorated mentally . . . The beauty parlor, ridiculed at first as a fad, changed all this. They now go about with their self-respect restored and in costumes that do not differ from those worn by an ordinary group of women." I might also mention the specially constructed beds for senile patients—each bed with a built-in, full length drawer for storage of the patient's most fondly cherished possessions, from bits of string to family photographs.

Numerous Violations of Integrity Occur

Another vastly important aspect of this concern for the patient's integrity has to do with the whole question of communication. It is fortunately no longer necessary to remind the young psychiatrist of the fact that even the most regressed patient hears and understands what is said in his presence and may be replying with a shift in position, a grunt, a difficult-to-understand neologism, etc. What is not always so scrupulously maintained is a sense of the confidentiality of the patient's communications to us, even in the most disturbed and seemingly removed patient. Psychiatrists, including this one, are (by training?) given to the delights of anecdotes about their patients, many of whom, it must be admitted, lend themselves admirably to this purpose for one reason or another. Gossip, for in truth it is just that, always has a certain malicious quality. The injunction against it, which should be absolute, must make clear that this is in fact a violation of the patient's integrity.

A fine illustration of the role of integrity as a factor in mental hospital procedure is the question of voluntary admission. Increasingly in recent years there has been general agreement that the attitude of the patient to his hospital stay is much more positive if he is admitted on a voluntary basis, that management problems are minimized and the prognosis improved. It is easy to understand this if we consider it as a matter of "integrity". Few things are more destructive to the patient than to be overcome physically, often by sheer force (rarely, it must be said, of necessity) or through chicanery and deceit, and it is understandable that a considerable effort at reconstruction must be made before the patient can again feel the trust in himself and hence in others that his integrity demands. And that is at the heart of the matter in the struggle for recovery in each patient: once more to be able to demonstrate to himself and to others that he is a whole man.

One more example must suffice. Such aspects of psychiatric care as occupational therapy are generally taken for granted these days, but here I should like to emphasize their potential contribution to the patient's sense of wholeness. In the most dynamic terms they serve important ego strengthening purposes, opportunities for reality testing, group activity, etc. They are significant elements in the patient's needs for integrity; his sense of wholeness must properly include a sense of his ability to function on a job and to bring it to satisfying completion. He must learn again the ego rewards of the fulfilled task, the gratification one can achieve through "production" both for others and for oneself, the instinctual satisfaction of working with tools and of making things.

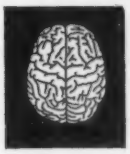
"Open Hospital" Emphasizes "Integrity"

This ego-building attitude toward work contrasts sharply with what Osmond calls the "peonage system: the dependence on unpaid or ill-paid patient labor". He goes on to point out the inequities of this system even though its justification as an economic necessity is obvious, and he concludes, "It is hardly necessary to state that slavery, under whatever guise, is harmful, and in my view, when it is maintained under the cloak of psychiatric treatment, it is despicable." These are strong words, but written by a man with a strong sense of the high demand on us to regard properly the patient's integrity. Indeed, his entire 1956 report to the Board of the Saskatchewan Hospital is couched in these terms.

Much of what we have been discussing is included in the concept of respect for the individual's ego. In discussing the stages of ego growth in the child, Erikson emphasizes trust as the first of our ego values, and points out in a characteristically trenchant remark: "The general state of trust implies not only that one has learned to rely on the sameness and continuity of the outer providers, but also that one may trust oneself and the capacity of one's own organs to cope with urges; and that one is able to consider oneself trustworthy enough so that the providers will not need to be on guard lest they be nipped."

This emphasizes and does much to explain the great and almost incalculable gains which result from the open hospital system and from the patient's greater opportunity to test his ego strengths and to find his sense of integrity granted and trusted. This need, to be able to trust, stems from our earliest infancy, (Erikson says, "The infant's first social achievement, then, is his willingness to let the mother out of sight without undue anxiety or rage . . ."), and the patient's opportunity to relearn and redevelop this aspect of his integrity must inevitably have a beneficial therapeutic impact. *To learn it, he must be trusted by those who have him in charge and they must, in turn, believe in his integrity as well as their own.*

"Trust" is defined in Webster as "the assured reliance on another's integrity". For the patient, as for the infant, to be able to learn this requires that, in turn, those responsible for his care respect his integrity, his right to be a whole man and to be treated as such. For our patients, too, must be helped to share Emerson's conviction that "Nothing at last is sacred but the integrity of your own mind."



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References:
1. Sainz, A.: Personal communication.
2. Hutchinson, J. T.: Evaluation of Pacatal in Psychotic States, address before the American Psychiatric Association, Nov. 16, 1956.
3. Bowes, H. A.: Am. J. Psychiat. *113*:530 (Dec.) 1956.

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MANAGEMENT PRINCIPLES AND A STATE HOSPITAL (II)*

Modern Practices Prove Their Value

By SAMUEL WICK, M.D.,
Superintendent, Arizona State Hospital, Phoenix

IN THE ARTICLE by Dr. Addison M. Duval in the October issue of MENTAL HOSPITALS the following definition of management is given: "Management is guiding human and physical resources into dynamic organization units which attain their objectives to the satisfaction of those served, and with a high degree of morale and sense of attainment on the part of those rendering the service."

This became meaningful to us after substituting the words *personnel* for "human resources," *hospital structure* for "physical resources" and *patients* for "those served." With these factors as a framework of reference, management principles can be applied to the hospital in order to reach the goal of providing the best patient care in a therapeutic environment. The final evaluation must depend upon the attainment of this goal, for our interest is focused upon "the satisfaction of those served."

Four years ago, the Arizona State Hospital was primarily a custodial institution with employees who considered themselves guards of "insane people" who had been sent to the hospital to remain for the rest of their lives. There were no written policies or procedures, no personnel department, no training program, divided supervision, and inadequate buildings which were overcrowded. It was necessary to formulate immediate plans and long range plans which were developed by using the management principles of planning in a) setting objectives, b) establishing policies and procedures, and c) assigning of responsibilities to individuals and organization units.

HUMAN RESOURCES

The immediate objective was to improve personnel attitudes and abilities so that patient needs would be met through better treatment methods. The objective was presented to all employees by education and communication so that their cooperation could be obtained. An educational program was established for all nursing personnel which was mandatory for employees who had been at the hospital for many years, as well as new employees, so that everyone would have the same understanding of the goal. Non-nursing personnel were also required to attend this training course because it was stressed that everyone in the hospital contributes to the therapeutic environment which is important for the care and treatment of the patient.

The results of the educational program were not immediately apparent because there was resistance to change, but with continued instruction by the nursing supervisors and the psychiatric aide supervisors in their contacts with the personnel on the wards, a gradual improvement was noted. The psychiatric aides developed the attitude that they were participating in the therapeutic program and that they were contributing to the welfare and ultimate discharge of the patient.

The need to develop and improve supervisory techniques resulted in a supervisory training course. Some of the personnel who were in these positions were not qualified, but with continued effort and counselling after their training, a gradual improvement has been observed. If our present salary rate were increased we could obtain personnel with experience and supervisory qualifications who would be more adequate in the beginning, but through the training program we have been successful in developing satisfactory supervisory personnel.

Written Procedures Developed

The training program indicated a need for written nursing procedures which could be distributed to the ward personnel. A committee composed of a nursing supervisor, graduate nurse and psychiatric aides was assigned to write the nursing procedures, which were reviewed and approved by the director of nursing and the hospital director. This resulted in the Nursing Procedures Manual, which is being improved constantly and to which additions are made continuously. Four years ago there were no written procedures and there was a lack of uniformity in the men's wards and women's wards because the director of nursing had supervision of the female personnel and the male supervisor had supervision of the male personnel. This was changed so that the director of nursing now has authority and supervision of all employees in the nursing service, so that the same procedures and policies are maintained in all sections of the hospital.

To implement objectives, it was necessary that hos-

* *See MENTAL HOSPITALS, December 1957.*

pital policies and procedures be written and distributed. Previously, methods were followed because these practices had been in existence for many years. It was necessary to ask "why" to determine the reason for the continuance of any procedure. The Hospital Procedures Committee was created to review, evaluate and establish procedures and policies for all hospital activities. At present this committee consists of the superintendent, assistant superintendent, business manager, director of nursing and personnel director, although in the beginning other department heads were included until the basic procedures were completed. As new procedures are discussed or old procedures are modified, the departments involved review and make suggestions before final approval by the Committee. By including various levels of supervision in the planning, the acceptance of the procedures is facilitated and the control is improved, for they are given the responsibility for the successful operation of the procedure.

Increased Salary Levels Obtained

Personnel problems were inadequate salaries, a 48-hour week, a turn-over of more than 100% a year and insufficient employees. Our personnel needs to achieve better patient care were presented to the Hospital Board and the Legislature so that an increased appropriation resulted in a raise in salary levels, a 44-hour week (which we hope to reduce to a 40-hour week), a reduction of turn-over to approximately 60% a year and additional employees. We did not receive the total appropriation requested but with the demonstration that improved patient care and increased discharges have resulted, we anticipate that more of the personnel needs will be met.

A personnel division was established for initial interview and screening of those applicants who would be referred to the department head for evaluation and recommendation for employment. Although the superintendent legally has the responsibility of employment, the authority has been delegated to the department heads because they will be responsible for the effective functioning of the employee. The performance of each employee is reviewed and rated by his supervisor. In the beginning the level of evaluation was high as it was expected that the rating would be used primarily for an increase in salary. Since then the supervisors have been given additional instruction so that they use the review as a means of discussing the employees' accomplishments, as well as the areas of their work which require improvement. Employees understand that increase in salary depends upon good performance as well as the budget limitations. Terminal interviews and follow-up letters after employees have left the hospital have been helpful in obtaining reasons for termination, so that personnel policies could be reviewed and modified to improve morale and working conditions. Job descriptions were completed for all positions in the hospital and now we are in the process of doing job analyses. This has resulted in an accurate organizational chart which shows the relationship of all employees and the line of supervision. Each employee knows to whom he is responsible and for whom he has supervision, which has eliminated much conflict and uncertainty as to the line of authority.

These methods have provided the hospital with better employees who have a sense of attainment and of participation in the treatment program for the benefit of the patients.

Physical Resources

The building program was projected on a five year basis to provide for the remodelling of five old ward buildings, for additional wards and new facilities which would meet the standards for accreditation. The program stressed the objective of producing a therapeutic environment by reducing overcrowding and providing adequate sleeping areas, dayrooms, toilet facilities and treatment activities. After one of the old buildings which housed the chronic, regressed, deteriorated women patients was remodelled, we could demonstrate the results by the therapeutic response in improved behavior, reduction of destruction, elimination of restraint and the discharge of 10% of these patients. These facts influenced the Legislature to appropriate the funds necessary to complete the first three-year phase of our building program. As each step is completed, the realization of our goal comes closer with the sense of accomplishment being reflected in the attitude of employees, greater acceptance in the community and continued support by the Legislature.

Budget Preparation Involves All Department Heads

The preparation of the budget has been a cooperative function which involves all departments of the hospital. Conferences are held to determine anticipated needs in current expenditures, capital equipment and personnel for the next fiscal year, and to review the adequacy of allotted funds during the current fiscal year. After the appropriations are passed by the Legislature, the budget is reviewed with each department to determine the distribution of available funds. Each department becomes responsible for using its portion of the funds most economically, with control being maintained by the business manager. The responsibility of assisting with the budget requests and with the distribution of funds has developed a feeling of participation and a better understanding of the monetary problems of the hospital.

Purchasing committees have been established to set standards and specifications for all supplies so that the product will give the best buy for the money. These committees have tested various items to determine which ones would best serve the hospital.

The purpose of all these projects is to provide better care and treatment. Even though the physical resources are important, it has been recognized that it requires trained people for the treatment to be successful.

We realize that as the immediate objectives are accomplished, the long range objectives must be modified to meet changing conditions. The primary goal has remained the same but the methods and procedures used to attain this goal require constant review and re-evaluation. The use of management principles has been and will be valuable for developing a hospital into a dynamic organization which attains the objective to the satisfaction of those served.

A PSYCHIATRIC WORD CLINIC

Session IV—Words Describing Withdrawal or Indifference

By HENRY DAVIDSON, M.D., Superintendent
Essex County Hospital, Cedar Grove, New Jersey

NOW WE REACH the last classification of words which we may use to describe our patients—words of withdrawal or indifference. If we characterized the "happiness" and "irritability" words as high-pressure words, and the words descriptive of sadness as "low key," this group may elude us. The words, like the patients they describe, show a lack of emotional tone. The danger here may be similar to the clinical danger we encounter. Just as we may make the superficial judgment that the behavior itself indicates nihilism or lack of emotion, so may we choose our descriptive word at random, believing that one "indifferent" word describes nothingness as well as another. Yet here too is a vast gamut of subtle descriptive meanings through which we must thread our semantic way.

These words are: *aboulia; apathy; blocked; bovine; cataleptic; comatose; demented; depersonalized; deteriorated; dull; evasive; flattened affect; mute; negativistic; passive; retarded; seclusive; shallow; stereotyped; stuporous; untidy.*

Aboulia (sometimes spelled "abulia") is inability to make a decision; a loss of will, or of ability to control. In Greek, *boulesthai* means "to intend." In aboulia, the patient may, in some vague way, have the wish to do something, but lack the power—psychological, not physical—to do it. In the popular sense this is "lack of will power"; more exactly, it is a deficiency in "psychic energy" or an emotionally generated barrier to carrying out an intent.

Apathy is an absence of emotional tone—a bleaching out of the qualities of sadness, hope, pride, shame, joy and so on. A casual glance may suggest that the apathetic person is sad, or *vice versa*. But sadness is a mood—in a way, a passion—and apathy is the "absence of passion." The Greek word *pathos* means suffering or passion. Apathy is, therefore, absence of that quality. Apathy is different from calmness. The calm person has mastered his emotions; the apathetic person has lost them. Actually this is an oversimplification. Persons who have been through schizophrenic episodes say that they experience very deep moods. But, on the surface, all emotional color seems to have faded out.

At staff presentations, patients are often described as **blocked.** This means that the flow of talk has abruptly been dammed—substantially slowed down so that the previous cadence of conversation is lost. The patient may stop talking entirely, or speak haltingly or in curt monosyllables—or unresponsively as if some semantic barrier existed between the examiner and the patient. "Block" is an old Germanic word for "solid," akin to "balk" or "beam."

A seldom used, but vividly descriptive term is **bovine.** Derived directly from the Latin for "cow," it means a combination of sluggishness plus (apparently) infinite patience.

Catalepsy, Catatonia and **Cataplexy** are cognate words. *Cata* is the familiar Greek prefix meaning "down," as in "catabolism" or "cathode." "Plexy" means to strike (as in "apoplexy"—to strike from). "Lepsy" means to seize (as in the word "epilepsy"). So cataplexy means "to strike down" and describes a loss of muscle tone, producing a transient immobilization or even a collapse of body musculature generally. Catalepsy is waxy flexibility—a plastic maintenance of posture, the arm or leg holding the same position to the point of fatigue. Catatonia is a phase of schizophrenia. The word "catatonia" means, literally, "down tonus," or, to phrase it idiomatically, "lowered tensions." Originally it referred to a cataleptic state—a condition of lowered muscle tension plus impaired consciousness. Thus, it connoted a stupor. Later, the word was extended to cover significant alterations in general muscle tone, whether in the direction of underactivity (catatonic stupor) or overactivity (catatonic excitement).

Coma and **stupor** are sometimes confused. Coma implies loss of consciousness. Stupor refers merely to a slowing down of consciousness; or if to unconsciousness, then to one from which the patient can be aroused by shaking. Coma is the Greek for sleep ("cemetery" meant originally a sleeping chamber and came from *koiman* to "put to sleep"). The dictionary defines "coma" as "profound insensibility due to disease," whereas it defines "stupor" as a state of diminished sensation, unresponsiveness and lack of body movement. Stupor is etymologically akin to stupid (stupefy), coming from the Latin *stupere.*

Generally these words are reserved for impairments of physical, rather than emotional, origin. A very depressed patient might appear stuporous if he is unresponsive. Usually "stuporous" means a physically caused stupor. But there is nothing wrong in applying "stupor" to an emotionally precipitated insensibility, though the word "coma" is never so used.

For many years the profoundest level of depression in manic-depressive psychosis was called "stuporous depression" or "depressive stupor." In the 19th century the terms "benign" and "malignant" stupor were used to differentiate manic-depressive from schizophrenic withdrawals. No effort was made at that time to separate organic from emotional stupors. However, in modern practice, unless otherwise specified, the word "stupor" is taken to refer to a physically caused impairment of sensibility.

Dementia is a gross impairment of mental faculties, such as an enfeeblement of intelligence, serious disorientation or major loss of reality-contact. The idiomatic feature of dementia is intellectual impairment. It is an acquired rather than a congenital impairment. Ordinary mental deficiency is *not* dementia; but the gross memory impairment and intellectual defect of some of the arteriosclerotic and senile psychoses *are* forms of dementia.

Mens is the basic Latin word for "mind" or "thinking." It covers the concept of "instruction" too. From *mens* come such words as monitor, mental, mind, admonish, memento and mention. Many psychiatrists prefer to limit "dementia" to an organically rooted decay of mental functions.

Depersonalization is used in three overlapping senses. The impairment of one's identity is a form of depersonalization; so is a delusion of being someone else. The word is also used to describe a sense that the arms or legs do not belong to one. Occasionally, the syndrome is inverted, and the patient believes that *he* is real whereas the environment around him is not. This used to be called "estrangement," a term now almost obsolete.

The Latin *sona* for "sound" (as in such words as "sonorous") may seem to be unrelated to "person." Actually the last syllable of "person" is identical with the first syllable of "sonorous." Greek actors wore masks through which they sounded their lines. Hence, *persona* was a mask, and became the symbol for the character played. Depersonalization then is the loss of character.

Deteriorate is an original Latin word meaning to make worse. Webster defines it as "made inferior in quality"; whereas degeneration is defined as a decline to a lower race or type or kind, rather than to inferior quality or value within the same type. To define the fall from excellence to mediocrity, Webster prefers "decadence." So the drop to something below mediocrity from an average status would be deterioration.

The technical distinction is between "defect" and "deterioration." "Defective" implies that the person always lacked the quality; "deterioration" that he had a normal amount but then regressed: "decadent" that he had a superior amount and then decayed.

Dull is used by the psychometrist to mean "in an 80 to 90 I.Q. bracket." To the psychiatrist, it means "lacking in sparkle; slow and blunt." Dull has two antonyms: brilliant and sharp. The Anglo-Saxon *dol* meant "foolish." The German cognate, *toll* meant "mad."

The dictionary defines **evasive** as "avoiding by artifice." To evade is to escape something unpleasant by ingenuity, dexterity, or subterfuge. *Vadere* is Latin for go, or walk; *evadere* is simply to "walk away." The English word "wade" has the same origin, and originally meant to walk against resistance. ("Evade" and "avoid" are historically different in spite of a current similarity of sound and meaning. The "void" in "avoid" is the word for empty"; originally "avoid" meant to empty out.)

Even with psychotics there is an implication of deliberate subterfuge when the word "evasive" is used. It implies that the patient *can* give a direct answer, but prefers not to because the direct answer is embarrassing. An unsatisfactory answer rooted in delusion is *not* evasion because it lacks this element of intentional subterfuge.

Flattened effect is one of the old reliable phrases of hospital psychiatry. It is a failure to display much emotional coloring. The word "flat" implies a lack of the ups and the downs, the peaks and the troughs, that are part of normal living. The Greek word *platys* means "broad" (platform, plate and so on), and, by implication, something "flat"—as in referring to a phonograph record as a "platter." Flat is an Anglicized version of *platys*. Since something is "smoothed out" when it is made flat, the word "flattery" is used for the process of smoothing someone out." Affect, as we have seen before, is the subjectively experienced effect of an emotion. Flattened affect, then, suggests apathy or indifference.

Mute describes a refusal to speak or answer questions. *Mutire* in Latin means to "utter feeble or incomprehensible sounds"—hence the English "mutter." It seems odd that mute (meaning, in effect, "no words") should have the same origin as the French *mot* (meaning word).

Negativistic means doing the opposite of what is asked. Originally it also covered the failure to do what was asked. In current clinical usage it generally refers to a resistant attitude plus the performance of the opposite—as to shut the mouth when asked to open it.

Historically, the word **passive** is akin to "passion," the latter meaning "suffering." At first, passive meant "being made to suffer by being acted upon," and from this there developed the current sense of "not active." In modern psychiatry, it means "easily controlled by outside forces" or "readily swayed." It carries some connotation of "apathy," too, which is unexpected, since "apathy" means "lack of passion," whereas, originally, "passive" means to "suffer passion."

Perseveration is a clinging to a thought, a repetition of an action, idea or phrase, an adherence to a pattern. The common word "persevere" is recognized within perseveration. The Latin *severus* means severe, and later extended to mean "strict," that is, obedient to a regime.

Stereotype is a monotonous repetition of a pattern or the maintenance of a gesture. It also includes the repetition of the same phrase over and over. Indeed, even an attitude can be stereotyped. Stereotypy of ideas is perseveration, defined above.

Stereo is a combining form, the Greek for "solid." Thus by extension, it means three-dimensional, as in the word "stereoscope." In the printing trade, there developed the custom of using a solid block of three-dimension mold to reproduce pictures. Since this became a way of reproducing identical pictures, the word "stereotyped" came to mean repeated without variation.

Retardation is used by psychologists to mean intellectual backwardness. To the psychiatrist, the word means simply a slowing of thought or speech. *Tardus* is Latin for "slow." The modern English adjective "tardy" means "so slow that the person or event is late."

(Continued on page 16)

Two days ago,

he was manic,

hostile,

aggressive

... today he is calm, sociable, easy to manage

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Seclusive means hard to reach, inaccessible, to be separated from others, withdrawn from intercourse with others, screened or shut off from others. The Latin *claudere* means to shut off and is akin to "close," Latin *clausem*.

The dictionary defines **shallow** as not deep, not profound, and therefore as superficial. Somehow in the word "superficial" there is an implication of pretense and insincerity, as if the person, or the treatment or the explanation were held out as being meaningful when it dealt only with the obvious surface aspects. But shallow carries no implication of such pretense.

Both "superficial" and "shallow" imply a concentration on the obvious. The flattened affect is itself a meaningful sign. Shallowness has only negative meaning. If the tears are not due to real psychic pain, but to a passing mood, easily changed to laughter, then the depressed mood is a shallow one, not a flattened one.

Untidy should be distinguished from "dirty." The basic concept of tidiness is orderliness and careful arrangement. Etymologically the word is related to "tide" meaning regular and dependable. The essence of tidiness is neither cleanliness nor simplicity: it is orderliness. "Untidy" has the double concept of careless and slovenly.

"Slovenly" in turn means lack of neatness, lack of order. (The female equivalent is "slatternly" but the gender distinction is now obsolete.) "Careless" means unwilling to take pains. So the concept of untidiness is "not taking pains to keep neat and/or orderly." There is an element of willfulness about "untidiness."

Basically, "dirty" means sullied or defiled. It can, of course, be non-willful. The word "dirt" originally meant excrement, and its extension to "soil" is modern. "Clean dirt" is a reasonable term currently, but not historically. One can be scrupulously clean, yet untidy; that is, every hair, every item, every article of clothing can be clean, but at the same time, disorderly and out of place.

CONCLUSION

And in the beginning is the Word. For with the first contact the examiner must paint in words his picture of the patient.

"Words well chosen," said Joseph Addison, "have so great a force that a description often gives more lively ideas than the sight of things themselves."

You do not find the precise word by dipping into a grab bag and pulling out the first item. You select the accurate terms with discriminating care from the dictionary's wonderful warehouse of words. You fit them neatly together to balance and enrich one another, as a painter works from his palette. This takes time and trouble, but of all your works and thoughts only the words you write will live forever.

The examiner's words—your words—are frozen on paper and stored in a cabinet. A year or ten years hence the words are still there to make you ashamed of slovenly words—or to do you proud.

For in the end, too, there is the Word.

VERBAL AMMUNITION

by DR. WHATSISNAME

IT SEEMS that clinical directors throughout the country are now disemboweling MENTAL HOSPITALS to get out the Word Clinic and pass it around the staff room.* "I expect to see" says the boss, "more vivid, more vigorous reporting now. No more of this routine stuff like 'patient depressed; insight and judgment poor'."

And many of the staff doctors are reported to be wallowing in the words thus offered. Charts are showing the effects of stringing words together like beads. One patient is written up as pensive, sad and woe-begone. Another is characterized as sated, grim and grief-stricken. Purple prose is beginning to burgeon in state hospitals. An examiner with an ear for alliteration has just described a patient as downcast, dejected, depressed, disheartened *and* disconsolate. And a staff doctor whose mother tongue is not English was heard asking an obstetrician to explain "melancholy baby" (blue baby, perhaps?).

"A word" said Nietzsche "is a preconceived judgment." Perhaps our Word Clinic, by sharpening the tool, has made it a more aggressive weapon. Time was when the ward physician had trouble explaining to a mother why he couldn't give her son that week-end pass. Because of his "condition." Kind of vague, you see. But now he has a fine assortment of tags to pin on the patient. "You see, we had better not give him a pass because lately he has been irrational, impulsive and irresponsible."

Or if that triad doesn't fit, he has been too exalted, elated and expansive. Or maybe paranoid, peculiar and preposterous.

One clinical director reports that, after surveying the ammunition now available in the verbal armory, he yearns for the good old days when a patient was only one of three things: depressed, elated or demented!

*** A reprint of the Word Clinic will soon be available from M.H.S. Price 50¢. Please send cash for orders less than $2.**

THE REISS PAVILION'S FIRST TWO YEARS OF OPERATION

Editorial Note: In May 1956 the Architectural Supplement of MENTAL HOSPITALS featured the Jacob L. Reiss Mental Health Pavilion of St. Vincent's Hospital, New York City, which had opened three months previously. Accompanying the architectural description was an article by the Director of the Reiss Pavilion, Dr. Harvey J. Tompkins, outlining the planned programs of treatment, research and training. In the brief report presented below, Dr. Tompkins recounts some of the developments which have taken place during the Pavilion's first two years of operation.

The Jacob L. Reiss Mental Health Pavilion opened on February 23, 1956 and was activated gradually, as staffing proceeded, so that by October 1956 it was in full operation with a capacity of 82 beds. As knowledge of its facilities spread in the surrounding communities, requests for services multiplied to the extent that as a rule the Pavilion now functions at from 85 to 95 percent of full capacity.

The type of psychiatric service that has developed orients itself toward the "community" concept of the large general hospital and it has accordingly been shaped by the demands of the community it serves. Thus the service offers quick hospitalization—after referral by personal physicians or other professional sources—early diagnosis and prompt treatment of the various types of acute psychiatric illnesses. In most instances the patients need be away from their homes and jobs only briefly; the average length of hospitalization is 37 days and the mean length of stay is 30 days. Sixty-nine percent of the admissions have been from the metropolitan area.

The outpatient department also strives to meet community mental health problems, and the demand for its services far exceeds the facilities available. This department, which operates as a low-cost clinic, emphasizes a careful, extensive workup of each case by the psychiatric team, which enables a better assessment to be made of the patient's difficulties before any course of therapy is embarked upon. In many instances it is found advisable to refer the patient to a social agency for help, and in some cases the patient gains sufficient understanding of his problems in the diagnostic sessions so that no further treatment is required. Thus the extra time spent in evaluating each case frequently saves the clinic from spending even more time in giving protracted treatment to a patient who would not benefit from it and treatment can be given to a greater number who do need it. Further, the results achieved in cases accepted for therapy seem to be more satisfactory.

Strides have been made in our training program—St. Vincent's Hospital is an affiliate teaching hospital of New York University, Bellevue Medical Center—with the recent approval of our three-year psychiatric residency program by the Council on Hospitals and Medical Education of the American Medical Association.

HARVEY J. TOMPKINS, M.D.

USES OF THE PAST

I. *Historical Perspectives*

THE PAST means many things to many people. Large numbers treat it with complete disinterest and a few by meaningful denial. Perhaps the majority consider it a potentially diverting subject which, at best, should be an avocation. Certainly the past does not receive the everyday recognition which it so rightly deserves. Its genetic importance becomes obvious when we consider that our present will shortly be the past of the future. The knowledge of how our present relates to the past will strengthen our understanding and perspective so that we can meet our future with increased vision and confidence.

The psychiatrist usually recognizes that the past is particularly relevant when he deals with his individual patient, but he is all too frequently ignorant of the traditions and historical movements in his own field. An awareness of the past is essential in psychiatry, for otherwise one easily can become lost in its breadth and complexity and in the emotional polemics that are apt to ensue. A study of the history of psychiatry reveals a disconcerting tendency to repeat the same mistakes, but it also brings to light useful concepts that have long been forgotten.

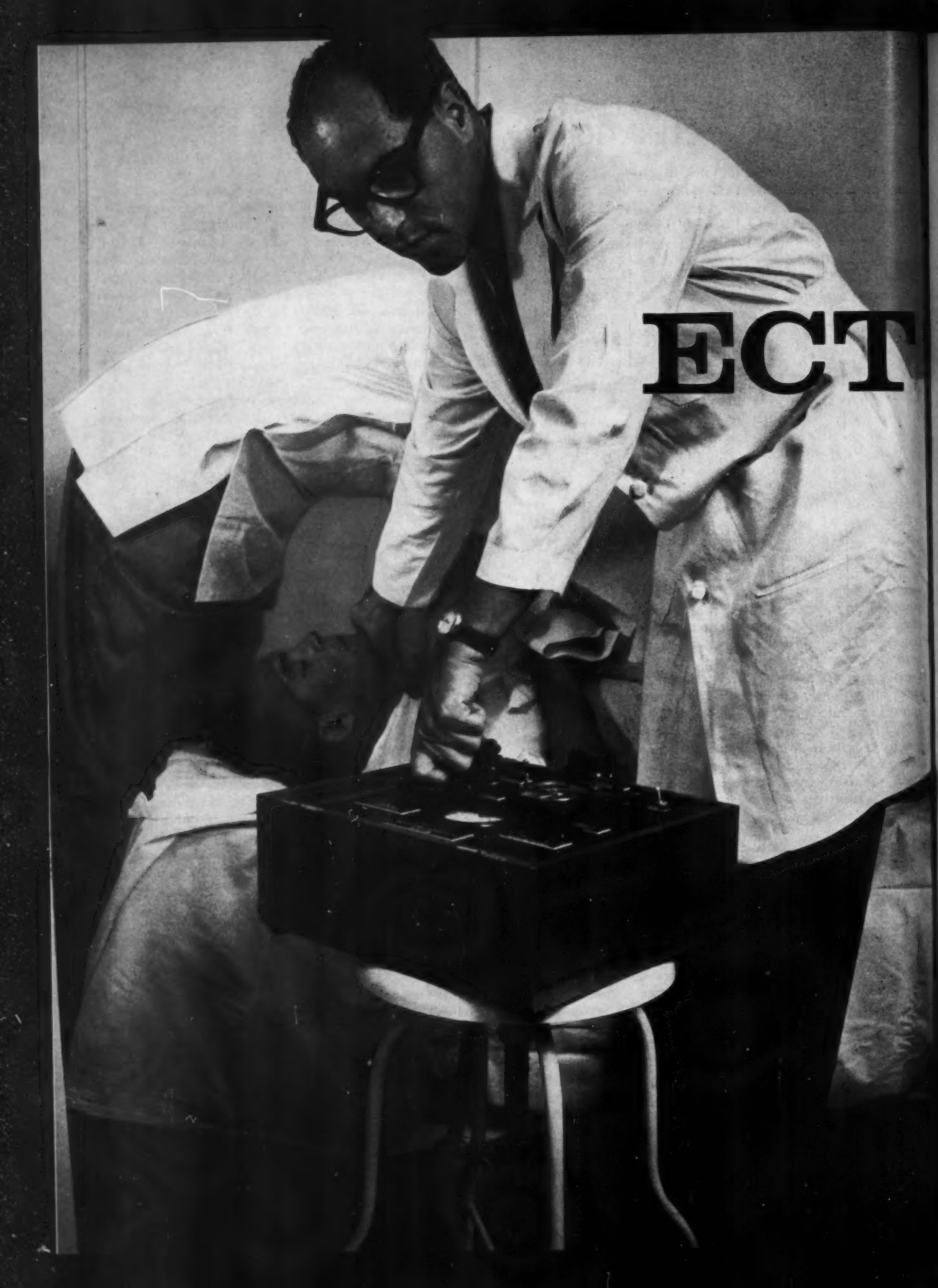
It is in recognition of these facts that the Editor of MENTAL HOSPITALS has made possible this article, the first of a series of intermittently regular columns to be devoted to the presentation of past concepts which apply constructively to current psychiatric theory and practice, and especially to the problems of hospital psychiatry. The title (inspired by H. J. Muller's *The Uses of the Past*, N. Y.: Oxford University Press, 1952) emphasizes the basic philosophy of stressing the utilitarian rather than what may be either esoteric or worthless.

The column will be the responsibility of the various members of the Committee on the History of Psychiatry of the American Psychiatric Association. This committee had its origin in 1941 during the ferment of plans to celebrate the A.P.A.'s one hundredth anniversary. The prime motivating force at that time was Dr. Gregory Zilboorg, who was appointed Chairman and continued in that capacity until 1955. Dr. Robert S. Bookhammer was the next chairman during 1955-1957.

The original committee, in cooperation with a special Committee on the History of Psychiatry of the American Association of the History of Medicine produced the well known volume, *One Hundred Years of American Psychiatry*, published by the Columbia University Press in 1944, in which fifteen distinguished authors discussed different aspects of the development of American psychiatry. Over the ensuing sixteen years, the committee also produced a number of exhibits, including the one on schizophrenia at Zurich last year.

The current committee is chaired by J. Sanbourne Bockoven with Fritz A. Freyhan, William K. McKnight, Leo Alexander, Earl D. Bond and Eric T. Carlson as members.

ERIC T. CARLSON, M.D., New York, N. Y.



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Following treatment with "DEPROL", fifty-seven per cent of patients with psychotic or neurotic depression experienced *complete or social recovery* within an average of 8 weeks without electroconvulsive therapy.*

- Relieves depression without euphoria—*not a stimulant*
- Restores natural sleep without depressive aftereffects—*not a hypnotic*

- Rapid onset of action
- Side effects are minimal and easily controlled

Composition: Each tablet contains 400 mg. meprobamate (2-methyl-2-n-propyl-1,3-propanediol dicarbamate) and 1 mg. benactyzine HCl (2-diethylaminoethyl benzilate hydrochloride)

Average Adult Dose: 1 tablet q.i.d.

**Alexander, L.: Chemotherapy of depression—The use of meprobamate combined with 2-diethylaminoethyl benzilate hydrochloride (benactyzine). J.A.M.A. In press, 1958.*

Literature and samples on request

WALLACE LABORATORIES, *New Brunswick, N. J.*

CD-5125

Regressed Patients Employed in Community

Some of the workers engaged in clearing land in the above photograph are patients of the Northport (N. Y.) VA Hospital who are employed by another institution in the community. They are paid the going wage of $1.00 an hour, which they receive in cash every two weeks. Most of their earnings they deposit with the hospital cashier, but periodically they retain some for an "evening out." Accompanied by a counseling psychologist, the workers enjoy dinner at a good restaurant in town and follow it with whatever available entertainment interests them.

The Community Employment Project was begun in July 1956, as an experiment, with four patients. It was planned for long-term regressed patients whose mental functioning is seriously impaired but who are physically healthy and strong, able to do manual labor. We felt that enabling them to make good use of their one area of competency, with consequent ego satisfaction, would have a beneficial effect upon their total functioning capacity.

The plan took shape when the aforementioned local institution offered to hire a group of patients to clear a wooded area. From the original four selected for the work, the number has increased to ten. One of them has been offered full-time regular employment; most of the others have gained open ward privileges and show marked improvement in overall functioning. The results achieved in such a short time are so encouraging that we look forward to expanding the program in the future.

HENRY TANNER, M.D.
Director, Professional Service

Recreation Plan for Pre-Discharge Patients

Peoria State Hospital, Illinois, recently initiated a recreation program especially for pre-discharge patients. Patients with a favorable prognosis for discharge are referred to the recreation department by the medical staff, psychology department and social service.

The program is designed to develop in these patients recreational interests they can enjoy in the community after discharge. Included are such activities as bowling, basketball, dramatics, picnics and other pastimes that are easily available in almost any community. In none of these activities do we try to develop great skill; rather we try to teach the patient just enough about them so that he will want to develop further proficiency after he leaves the hospital.

The program is based on the premise that discharged patients who can make constructive use of their leisure hours will find it easier to readjust at home and will be less likely to require readmission.

DON F. WILSON, Recreation Supervisor

Long-Term Patients Receive Job Training

The long-term patient who, on discharge, cannot compete on the labor market for even the simplest of jobs is only half-rehabilitated. To meet this difficulty the Social Service Department of Spring Grove State Hospital, Maryland, combined with the Vocational Rehabilitation Division of the State Department of Education and with Eudowood Sanatorium to set up a simple, on-the-job training program.

Eudowood is a 170-bed nonprofit sanatorium for tuberculars located near Spring Grove. For years it has employed and helped rehabilitate abler patients from the state hospital; under the new plan it agreed to take as trainees men patients who had been hospitalized five, ten or even twenty years and help them learn the rudiments of community living.

The trainees live in an attractive cottage at Eudowood and work in dietary, maintenance, laundry and ward services where they not only receive training in specific tasks but also develop acceptable work habits. Social matters, such as personal appearance, recreation, and independence, are discussed in group sessions with the state hospital social worker. These sessions are important in rehabilitating patients who have been hospitalized a long time, since many are initially careless of their personal appearance; few remember the social amenities or the simple operations of using a telephone, riding on a streetcar or buying small items with money. All are sadly lacking in self-confidence and initiative.

The training period is from four to five months, during which time the Vocational Rehabilitation Division and the hospital share the expenses of maintenance; the hospital supplies clothing, cigarettes and $10 a month spending money each. The cost per trainee is between $425 and $525 for the full course.

At the end of one year, 10 of the 15 patients enrolled had "graduated" and nine of them were employed at regular wages. Another is obtaining additional specialized training elsewhere. Only five were unable to complete the course. One man, after 20 years in the hospital, had been so fearful of people that he would talk to his social worker only with his back turned. After a few weeks at Eudowood he spontaneously met him at the gate to take him to the trainees' cottage.

Additional patients are now in training and a similar project for women is being considered.

HELEN PADULA, Chief Supervisor
Social Service Department

Pet Show Is 'Howling Success'

A recent evening program at Osawatomie (Kans.) State Hospital was literally "a howling success."

The occasion was the presentation of a pet show by the employees for the patients. A large number of patients attended the show as 14 dogs, four cats, a horse, a raccoon, a parakeet, and a large aquarium of fish were placed on display and paraded, for a full evening of entertainment.

The pets ranged from registered pedigrees to the "Heinz 57" variety. Many were entered by adults, but most were shown by children. The seven puppies especially received much attention.

The fish aquarium display entered by an aide was the real crowd gatherer. It had miniature African catfish, Chinese carp, Brazil zebras, blood and ink moonfish, Siamese fighting fish and several other varieties, in seven large tanks. The most popular was the bowl of two "invisible" fish from Paraguay. This display won the ribbon for the most unusual.

Each entry in the show received a gold ribbon, and additional awards were presented for all special events.

NEWS-BULLETIN
Kansas Dept. of Social Welfare

Volunteer Teaches Puppet-Making

Patients at the Central State Griffin Memorial Hospital in Norman, Okla., are treated to weekly puppet shows staged by a volunteer. Mrs. G. C. Branson, a housewife who has been a professional puppeteer, spends one day a week at the hospital working in the Occupational Therapy shops of two buildings. In addition to putting on shows with her own marionettes, she is teaching patients how to make and handle their own puppets. A class of ten is busily engaged in fashioning the dolls, which have heads made of a glue and sawdust composition and bodies of sawdust-filled bags, and designing costumes for them. Mrs. Branson hopes her pupils will learn to make and operate the puppets sufficiently well to stage their own puppet show.

Delaware to Set Up Day Care Centers for Severely Retarded

The Legislature of Delaware has just passed a bill to establish day care centers for severely retarded persons. The plan, which is to be administered under the state mental health program, will be tried for two years, on a budget of $80,000 a year. It is intended for mentally retarded persons of any age "deemed to be not trainable or educable in public schools."

Such individuals will receive day-long care at the centers and transportation to and from their homes. The first center has been established at Georgetown and others will be set up throughout the state as needed. The care will be given by "training aides" who will receive a month's orientation at the Delaware State Training School, at Stokely. Each center will have one aide for each six persons enrolled.

A separate bill, passed in the same legislative session, provides special classes for the educable and trainable mentally retarded (as well as for other handicapped children of school age). These are to be established by the State Board of Education in public schools throughout the state. A provision of this same bill will assign ten teachers to the State School to work with trainable patients. A previous school bill provided five teachers for educable patients at Stokely.

Special System Circulates Mental Hospitals to Over 250 Employees

By DOROTHY F. MORTON, Medical Librarian
Osawatomie State Hospital, Kansas

OUR HOSPITAL has been receiving MENTAL HOSPITALS regularly since 1951. When I took over management of journal subscriptions for our medical library, I soon realized that, because interest in this magazine was so widespread throughout the hospital, the usual method of circulating journals would not suffice. A questionnaire we sent around showed that no less than 257 employees wanted to see MENTAL HOSPITALS each month!

We have ten copies available to meet this demand, the other five of our 15-copy monthly quota being sent directly to the superintendent and other key personnel who have need of personal copies. So we set up a special system, dividing the 257 requesting employees into ten groups according to their similarity of occupation or interests and to their physical location in the hospital. This grouping not only promotes quicker circulation of the copies but also encourages discussion among readers.

A small card file is maintained for the few journals we do circulate around the hospital. To keep track of the MENTAL HOSPITALS distribution we keep a reference card which shows the membership and location of each group and a circulation record card on which we note the dispatch and return of each copy to and from its assigned groups. (A Gray Lady volunteer helps with this.)

When the current issue arrives it is posted to the subscription record catalogue and the ten copies are earmarked for their respective groups. This is done by stapling to each copy a circulation slip listing the name and location of each person to whom it goes. The circulation slip gives the name and issue of the publication, the date on which it is sent from the library, and has space for "remarks," which we use to call attention to articles of special interest.

The magazines reach their destination via the "Interdepartmental Mail." Each reader initials the circulation slip before he sends the magazine on to the next person on the list. Since the Interdepartmental Mail service picks up and delivers twice a day, it is possible in most cases for everybody to read the current issue before the next one is due. At the end of their rounds the magazines are returned to the medical library.

We feel that the interest taken in this publication justifies the special procedure we use to distribute it throughout the hospital.

HELP PSYCHIATRIC PATIENTS TALK

New Parenteral Ritalin helps patients to verbalize and

makes them more cooperative. Onset of action is rapid. The mental alertness of patients is sharpened in as little as

five minutes.

"...it has been found most valuable in helping the patient to express himself during psychotherapeutic interviews."*

NEW PARENTERAL

DOSAGE: 10 to 20 mg. intramuscularly, 10 to 15 minutes before interview

Ritalin®

hydrochloride
(methylphenidate hydrochloride CIBA)

SUPPLIED: Multiple-dose Vials, 10 ml., each vial containing 100 mg. Ritalin hydrochloride in lyophilized form, accompanied by a 10-ml. vial of sterile solvent.

ALSO AVAILABLE: Oral Ritalin in tablets of 5, 10 and 20 mg.

*Waggoner, R. W.: Personal communication.

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Letters to the Editor

Status of Chaplaincy Training Programs Clarified

Dear Dr. Blain:

We were happy to see the January cover feature and to learn of the institutional chaplaincy program at the Hastings State Hospital. This type of state-sponsored training has been in existence for some time, beginning at the Elgin State Hospital in Illinois. We (chaplains) are grateful to the many state hospitals who have opened their doors for the training of ministers.

The Mississippi State Hospital began such a program two years ago. We have two levels of training, with summer classes in Clinical Pastoral Education which are accredited by the various participating seminaries. These men do their work in the hospital and get credit for the work at the local seminary. The second level of training is the Chaplain Intern level. These men are paid a stipend of $100 a month plus room, board and laundry. They are in residence for this training from six months to a year. (Their training is conducted) under the direction of the Chaplain Supervisor and the psychiatric staff.

Another plan which we feel is having great influence in our state is an annual one-day Institute for pastors. Last year we had over three hundred ministers attend and we expect around five hundred for this year's conference.

C. K. PEPPER,
Chaplain Supervisor

Another reader, who prefers to remain anonymous, also wrote us about the January cover story, taking issue with its first sentence: *"The first state-sponsored training center to offer a complete training course for institutional chaplaincy practice, designed for the clergy of all faiths, is now in operation at the Hastings State Hospital, Minnesota."*

This reader felt that the statement conveys a false impression and deserves clarification. He made the point that it "completely ignores the several decades of work of the Council on Clinical Pastoral Training." His letter continues:

"There are centers in state hospitals which offer complete training for institutional chaplaincy and which are open to the clergy of all faiths. The fact that all faiths do not choose to use these facilities is an entirely different matter, and the fact is that all faiths have actually used these facilities in the past, even though they sometimes did so without the official sanction of their particular denomination."

Editor's Note: It was not the intention of MENTAL HOSPITALS to ignore or slight the splendid work of the Council on Clinical Pastoral Training. We are happy to dispel any false impression which may have been given in our earlier article.

No. 7 in a Series

ADMINISTRATIV
Feature
Of The Month

MANAGEMENT AND THE BUSINESS ADMINISTRATOR

By F. A. MATHESON,

Business Manager, Provincial Mental Health Services, Essondale, British Columbia

WHILE the principles of scientific management are necessary in all departments of a modern mental hospital, they are absolutely essential to the business administration section. It is the business manager's responsibility to see that all departments of the hospital are properly supplied and equipped to carry out the treatment program and care of the patients and, as a result, he is responsible for the expenditure of many millions of dollars of public funds.

In order to properly discharge his duties and responsibilities, the business manager must clearly understand what these duties and responsibilities are and must then be given the necessary authority to carry them out.

Planning

Top administration will have formulated the program of care and treatment of patients, and this must be made clear in every detail to the business manager. He must then convert this treatment program into dollars and cents, forming the budget for the next fiscal year.

If the budget is appropriated in full, the program goes ahead as planned, but if, as so often happens, cuts in the budget are made, the appropriated budget will not cover all of the planned services and the plan must be revised to fit the appropriation. In this manner the budget becomes not only the basis but a control of operations and should reflect in detail top management policy in the treatment and care of the patients and the operation of the hospital.

Controlling

Because it is one of the responsibilities of the business manager to control expenditure and provide financial reports on the operation of the hospital, it is most necessary to have a well organized and efficient accounting system to provide the necessary information to carry out this responsibility.

Using the budget as a basis of control, the accounting department should be so organized that at the end of each month a report can be submitted, showing in detail the operation of the various departments of the hospital. These reports are also used by the business manager to keep a check on expenditures and to make sure that each department is operating within its budget. At the end of the fiscal year, a complete report on the year's operation should, of course, be prepared and this report, when compared with the budget, should show whether or not the policies laid down have been carried out.

Delegation of Authority and Supervision

The service departments of the hospital that are the direct responsibility of the business manager, such as the stores, pharmacy, maintenance, engineering, laundry, transportation, should be organized to provide the necessary services and supplies required by the treatment team. In order that these service departments may operate efficiently, the business manager must delegate the necessary authority and responsibility to the heads of these departments. He must also make sure that each one fully understands what his responsibilities are and how his department fits into the overall operation of the hospital.

Regular meetings should be held with heads of the various departments so that the problems occurring in the departments can be discussed and solutions found without delay. In addition, the heads of all service departments should also submit a monthly report on their operations.

If the business manager and the service departments that he is responsible for are to function efficiently, it is necessary that the business manager be a member of the policy-making committee. This is essential because any change in policy is reflected in the budget requirements and/or demands made on the service departments, and arrangements must be made to put these changes into effect without undue delay.

Communication

One of the most difficult problems in a large mental hospital is that of communication. Regular staff conferences and the submission of written monthly reports are the best tools to achieve good communications. I have mentioned above the necessity of these in connection with the service departments. It is also necessary that the business manager have regular meetings with the director, medical superintendent, clinical director, director of nursing, etc., so that mutual problems can be discussed. The business manager should also submit a written monthly report to the director or medical superintendent detailing the operation of the business administration department for the month. It is only in this manner that the director or medical superintendent can be kept informed on the operation of the hospital.

Review and Appraisal

The business manager should constantly review the operation of the various departments for which he is responsible, to make sure each is performing its duties efficiently. He should at all times be looking for ways and means to improve each operation, as the functioning of all departments of the hospital reflects on the treatment and care of the patients.

We Cut Our Fuel Bill By $25,000

By JOHN L. ROCK, Business Manager
and THOMAS A. MANCHESTER, Engineer
Butler Health Center, Providence, Rhode Island

BUTLER HOSPITAL in Providence, R. I. was founded in 1844 and grew year by year, until it consisted of 20 buildings heated from a central heating plant. In 1955 the Hospital was closed in the face of apparently uncontrollable mounting deficits. During the two heating seasons which intervened before it was reopened in 1957 as Butler Health Center, sufficient heat was maintained throughout the buildings to prevent damage and to keep the wet pipe sprinkler system activated.

During the last full years of operation, the annual fuel bill amounted to $59,000, a whopping item of overhead. Even while the Hospital was closed the cost of fuel came to a yearly figure of $35,000. This item of fuel cost was one of the factors with which the Hospital board was vitally concerned as plans for reopening the famous institution were being formulated. To reduce this cost substantially was one of the major challenges faced by the new staff which took over the operation of Butler early in 1957.

An engineering survey of the heating plant drew the not unexpected conclusion that a complete overhaul was desirable. However, even rough estimates made it apparent that this was financially out of bounds. "See what you can do," the Board told us, in effect, "to get that antiquated plant back into something like effective and efficient operation. You'll have to spend money, of course, but measure each expenditure in terms of what it will save in fuel costs and let us see how well we can do."

Coal Prices Low

Obviously our first move was to check fuel prices in the area to see if there were savings to be made here, but we found that we were buying coal at $1.50 per ton less than any other quoted price. It was evidently a job of engineering and we went at it from that angle.

Since our own staff was neither large enough nor experienced enough to handle it, we called in Carl F. Brugge Company, one of the best local heating contractors and along with our Consulting Engineer, William S. Allen, we all tackled the job.

The plant consisted of four boilers. Fuel was fed automatically, but water was supplied manually. More than 80,000 feet of steam lines and return lines ran from the plant to the various buildings through underground passageways. About twenty-five per cent of the valves were of the automatic control type, but these were at the furthermost points of the system. In the majority of the heated areas the heat simply "ran wild" which, of course, resulted in either waste or inadequacy and brought continuous complaints of too little or too much heat, as you would expect.

Our first step was to replace manual water feeding with automatic pump controls. This involved the installation of two new Worthington feed water pumps and one 750 gallon tank, adequate to take care of any two of our four boilers. This improvement immediately resulted in fuel savings, since it kept our water levels constant and prevented the addition of cold water in large quantities at any one time and the consequent reduction of steam pressure which almost always occurred at times when we needed it the most.

Spring came and it was a good time to check all traps in the line and to inspect the lines themselves. This we did and it became apparent that virtually no maintenance work had been done on the system for at least twenty years. Signs of neglect were everywhere. Traps were rusted open and rusted closed. Return lines were rusted out and pockmarked with holes. We were losing costly steam and return water at a score of points.

We replaced 2,500 feet of return line and installed motorized thermostatically controlled valves* at all points, but we were still having trouble getting the desired amount of condensate back to our boilers. We were using about 25% of cold make-up water which, of course, was a tremendous factor in cutting efficiency.

We replaced all bucket traps and undersized thermostatic traps with Float and Thermostatic type traps** big enough to do the job. These, now that rusted out return lines had been replaced, began to show us real savings in fuel consumption. We are now down to nearly 5% cold make-up water. In 1957 we showed savings of 900 tons of fuel below the amount used for minimum heating while the hospital was closed and almost 1,600 tons below the amount used when it was in full operation.

Sizable Fuel Savings Apparent

Thus far in the 1957-58 heating season we can account for fuel savings of approximately $25,000, nearly 50% of previous full-operation costs, and, at this writing, we have three months to go. When our fully automatic oil burners are installed next season, we shall have still further savings in our fuel costs, a prospect which pleases our financial people as much as it does our engineers.

To accomplish these savings we have spent, thus far, about $12,000 in materials and labor. The cost of our new oil burners will be something like $17,000. Yes, it costs money to save money, but we are on the right side of the ledger.

In a period when rising costs of hospital operation are of enormous concern to everyone in the field, it will pay almost any institution, and especially those with over-age heating systems to look carefully into the possibilities of reducing fuel costs through wise and practical expenditures.

** Minneapolis Honeywell 2½" motorized valves CV-#63 and 3" motorized valves CV-#100*

*** Strong, float and thermostatic traps #11-T, and 13-T (manufactured by Strong, Carlyle & Hammond, Cleveland, Ohio.)*

Minnesota Institutions Exchange Farm Products

Farm produce from the thirteen state institution farms in Minnesota varies widely. Soil and climate in the north favor production of rutabagas, cabbage, cauliflower, beets and berries and are detrimental to growing tomatoes and sweet corn.

The state has a program of exchanging commodities between institutions. For transportation we use farm trucks late in the fall when farm work slackens, arranging two-way hauls when possible.

The main advantage of this program is that products of the highest quality can be produced. For instance, the rutabagas from the Moose Lake area are the very best in sweetness and flavor. In the Red River Valley one institution produces most of the potatoes because it is a fine potato area. Another advantage is that the special equipment needed for some crops, such as pea viners, need not be maintaned at each institution. And crop failures or unexpectedly large yields can be equalized.

LESTER K. KNIGHT, Farmer
Moose Lake State Hospital

Property Control Procedures Simplified

Because of the considerable investment in supplies and equipment necessary for hospital operation, the Veterans Administration, which operates 172 hospitals of all sizes and types, conducts continuous research into the development of more efficient record keeping and warehousing practices. Recent studies have shown that about 50% of stock items handled in hospital supply activities account for less than 5% of the total value of all issues. It was therefore determined that this segment of stock should be isolated for replenishment at less frequent intervals, accorded only the simplest type of accounting techniques, and handled with a minimum of formal controls.

Expendable items (except groceries and security items such as narcotics, which by their nature require more rigid control) that fall within the category of the 5% annual issue valuation are identified as "low sales" items. For these items, no individual record cards reflecting receipts and issues are maintained, and the items are physically segregated in the warehouse. When replenishment is necessary, up to 12 months supply is purchased, and issues are made no more frequently than every three months. A safety level representing a three month supply is established for each item, and this quantity is set aside from the balance. When, at the time of issue, it is necessary to break into the safety level, the purchasing department is notified, and procurement action is taken.

Adjustments in the content of the "low sales" group must be made periodically depending upon the nature of individual items and local circumstances, but these simplified procedures, by eliminating a considerable amount of record keeping, allow more efficient use of warehouse personnel, and have reduced the number of back orders to the using departments to an absolute minimum.

WILLIAM F. O'GRADY
Chief, Supply Division
VA Hospital, Brockton, Mass.

NEW LOOKS FOR OLD

J. RUSSELL MILLS, Business Manager
Osawatomie State Hospital, Kansas

IMPROVING the appearance of buildings sixty or seventy years old without major remodeling is a problem which constantly confronts hospital superintendents and business managers. When patients, because of overcrowding, must remain in the area which is being renovated, this adds to the problem.

At Osawatomie State Hospital, we felt that the hospital administration should maintain close control over the workmen, and for this reason we got permission to hire employees at the regular Civil Service salary, to purchase materials and charge both items to the special funds which had been appropriated. Close cooperation between the nursing service and the maintenance department allowed the work to be done with a minimum of inconvenience to the patients in the area.

Several basic repair jobs were needed, among them new electrical wiring. The use of exposed conduit reduced labor costs and time. We used low price fixtures throughout because these old buildings will be razed within the next decade. However, outlets and switches were made accessible to the patients as well as to the nursing personnel, with the result that the lighting system gives more satisfaction to everybody.

New forced-air radiators were installed in some areas to provide adequate heating. To allow circulation of air into the patients' bedrooms that are closed at night, the top section of each door was removed and expanded metal installed. Some old-style radiators remained in service, and covers were installed on these to prevent injury to patients from burns. Installation material on the vertical steam pipes was protected by a galvanized iron cover similar to a stove pipe. The hospital's tin shop made this.

Some 1200 windows in one building needed repair, and some had to be totally replaced. Each window was inspected to determine what repairs were needed to extend its useful life for another 15 years; repairs were made accordingly and the whole job was done at an average cost of less than $25 a window.

But the renovations which really made a difference to the appearance and livability of the old building were fresh paint, new furniture, drapes and flowers. The day rooms and dining areas were painted a light green with white ceilings to increase the lightness of the rooms. Small rooms were painted in various soft colors according to the choice of the patient and the relation of the room to exterior light.

Old rocking chairs and railroad-station type benches were replaced by plastic and chrome loose-cushion lounge chairs and settees arranged in "conversation groups" and for watching television. Corner and end tables, writing desks and straight chairs were also purchased. We didn't throw out the rocking chairs: they were refinished in the occupational therapy department and found renewed usefulness in the patients' bedrooms.

The hospital sewing room made some 4,000 drapes; these were treated with a solution of borax and boric acid which makes them fire resistant but does not damage their appearance in any way. Finally, potted plants, cut flowers and vines are furnished regularly by the hospital florist to help create bright cheerful rooms.

Because patient destruction of property has reduced considerably since we got our "new look", we feel that the cost of the repairs has been largely offset. Even more important, of course, are the patients' feelings about the more pleasant atmosphere. Every time we look at the renovated areas we think of the motto which we adopted in 1954, when the improvement program was first started—"It's how you live, you feel."

Official News-Sheets Replace Rumors

One of the secrets of good management is good communications. Information from the top level down always seems to follow the usual institutional trend of filtering from one level to another and having no semblance of the original report when it reaches its final level.

It has been found most satisfactory at Enid State School, Okla., to establish three types of communication. A great deal of time and effort go into all of them, but they pay dividends in the long run.

THE ENID STATER is a publication now in its eleventh year. It is published in the school print shop and contains a lead story about an outstanding event of the school plus simple items from each cottage detailing interesting activities. Nearly 2,000 copies are mailed out each month to parents, relatives and friends of the school. This provides an opportunity to publicly thank those who have done things for us, and makes our needs known to others.

THE BUZZIN' BEE is the employees' newsletter. It is a mimeographed publication which goes out twice monthly to emphasize orders which might have been given verbally and to detail coming events. It is an excellent means of repeating information which every employee should have in regard to operation. New procedures, changing methods and the like, are reported. Weekly meetings of administrative staff and cottage supervisors are held, and discussions which might interest other employees are reported in the "Bee." The slogan here is, "It is correct if you read it in the Bee."

THE PARTY LINE is a mimeographed publication originating in the Superintendent's office. It is directed to the pupils. A great deal of time and effort is put forth to make this twice-monthly publication interesting and attractive. Outstanding activities by individuals are mentioned, problems which arise on various cottages occasionally are reported, etc. This is an excellent means of "praising" a child for a job well done or "regretting" a misdemeanor of another. Pupils' Cottage Council meets monthly with the Superintendent and the psychologist, and their discussions are reported in the *Party Line*.

Much misunderstanding, confusion and spreading of inaccurate information is avoided by these three publications.

ANNA T. SCRUGGS
Superintendent

Special Canadian Institute Issue

The May issue of MENTAL HOSPITALS will be devoted to the Proceedings of the First Canadian Mental Hospital Institute held in Toronto, January 20th through 24th.

Publication of the Proceedings is being subsidized by a generous grant from the Smith, Kline and French Laboratories.

A copy of the issue will be sent to all who attended the Institute, as well as to all members of the Canadian Psychiatric Association. This is in addition to our regular subscribers.

The topics it will cover are: relationships with other community medical facilities; mental hospital/community relationships; the forensic patient; the emotionally disturbed child; from custodial care to modern therapy; the open door concept; public relations; volunteers; day and night hospitals; rehabilitation services; the role of non-psychiatric professionals; addiction; research potential; and teaching in the mental hospital.

The Academic Lecture delivered by the Hon. Walter S. Maclay, "Experiments in Mental Hospital Organization," will be published separately and sent as a Supplementary Mailing to all subscribers in the near future.

Achievement Awards—A Reminder

The closing date for applications for the Achievement Award is April 15th. The Awards will be announced and presented at the Mental Hospital Institute in Kansas City in October.

Each application should be no longer than four to six double-spaced typewritten pages, and may be accompanied by supporting material. Four copies of each application and four sets of supporting material are required.

Please address them to Achievement Awards, A.P.A. Mental Hospital Service, 1785 Massachusetts Avenue, N.W., Washington, 6, D. C.

The American Psychiatric Association

and the American Institute of Architects announce

THE SECOND MENTAL HOSPITAL DESIGN CLINIC

March 18th-19th, 1958

Conference Room, American Psychiatric Association, 1785 Massachusetts Avenue, N.W., Washington, D. C.

THEME: Discussion of Specialized Psychiatric Facilities, Having Broad Design and Therapeutic Implications

Appraisal of:

1. A combined medical rehabilitation and psychiatric treatment center
2. A children's custodial unit for helpless mental defectives
3. A colony for high and middle grade mentally defective children
4. A teaching and treatment center for emotionally disturbed children

The Clinic is subsidized by a grant from the U. S. Public Health Service, and a registration fee is being charged to cover overhead and the publication of the proceedings.

Professional Staff

Daniel Blain, M.D., Medical Director, A.P.A. **Charles E. Goshen, M.D., Architectural Study Project**

Guests and Consultants

ARCHITECTURAL Feature Of The Month

New Trends in Psychiatric Architecture

A Report on the First Mental Hospital Design Clinic

By JOHN A. OUDINE

EDITOR'S NOTE: A full account of the Proceedings of the Clinic with illustrations and plans will be published soon.

Is there any single design or group of designs that could be considered as a satisfactory prototype for today's mental hospital?

Is there any set of blueprints that could be turned over to the hospital administrators and legislators in answer to their questions on the types of mental hospitals to follow as models in converting their structures for today's needs and building for tomorrow's demands?

The first Mental Hospital Design Clinic, sponsored by the American Psychiatric Association, did not pretend to provide any such solution when it met for a two-day session in mid-January at the A.P.A.'s headquarters in Washington, D. C.

What the Clinic did achieve was to lay the groundwork for a program which, it is hoped, will lead to a set, not of blueprints, but of principles of good psychiatric hospital design. This Clinic, an experimental effort financed under a grant by the U. S. Public Health Service, will be followed by others which will pursue problems posed by psychiatrists, architects, legislators and administrators on the care and shelter of the mentally ill and mentally re tarded.

Photo by Wessel & Associates

The new look in hospital lobbies is unthreatening and "normal" like that at Eastern State Hospital, Lexington, Ky. (Huntington Furniture Corporation, manufacturer.)

The second Clinic is to be held at the A.P.A. offices on March 18 and 19. (See Page 29 this issue).

Dr. Daniel Blain, Medical Director of the A.P.A., began the heavy schedule of the Clinic with a brief report of the Association's long interest in mental hospital design, which led to the establishment of an Architectural Study Project some four years ago.

The Clinic was presided over by Dr. Charles E. Goshen, head of the Architectural Study Project. The function of this and future Clinics, Dr. Goshen said, is to serve as an informal—and unofficial—sounding board and clearing house for new ideas, presented by prominent and respected experts in their fields.

Four teams of medical-architectural-administrative specialists represented mental hospitals in Saskatchewan, Canada; and in Ohio, Indiana and Delaware. An opportunity to witness the type of mental hospital construction in other nations of the world was also provided, through a report illustrated with color slides of facilities in eleven nations in Europe and Asia visited by Alston G. Guttersen, A.I.A., under sponsorship of the World Health Organization.

A report of development in hospital interior decoration and furniture design was contributed by Mr. Colin McLean, well-known as a consultant who works exclusively in the field of hospital needs.

Extensive discussions followed the submission of each report. Although requests to participate in the Clinic were received from more than 100 specialists in mental hospital design and furnishings, it was decided to limit the number of participants in the first Clinic to 38.

The Saskatchewan Team

The first psychiatrist-architect team to report to the Clinic was the brilliant combination of Dr. Humphry Osmond, Superintendent of the Saskatchewan Hospital, Weyburn, and Mr. Kyo Izumi, architect, of Regina, Saskatchewan, who have worked together for the last three years on the concept of psychiatric hospital requirements based on the needs of the patients who will occupy them.

Dr. Osmond, presenting the problem which is facing us today—approximately 800,000 mentally ill people in North America shut up in nearly 500 "fortresses"—called

for a new approach to the design of mental hospitals. The structure of most such institutions today and in past decades, he states, has been characterized by an "insensitive, hygienic, well-regulated hopelessness" that is aimed more at custodial care of the patient rather than helping him to get well.

From what is known of mentally ill people, particularly the schizophrenic, Dr. Osmond has established what he considers a set of requirements for mental hospitals aimed to prevent "desocialization," that is, to avoid any further loss of a patient's social skills, and to bring about "reculturation" by helping people who have become alienated and expelled from the community to regain those social skills.

He discussed his theories on the effect of overcrowding in mental hospitals, overconcentration of patients in large day rooms, space perception problems brought about by such structural factors as long corridors and high, oversized wards, the need for privacy, the preservation of the patient's personality and his psycho-social needs.

The Architect's View:

Mr. Izumi discussed the problem of the architect who is expected to design a psychiatric hospital without knowing the full facts about the people who will occupy it. The architect's first job, he said, is to establish rapport with the psychiatrist, collaborating with him in order to create a design which meets the needs from the therapeutic viewpoint. Mr. Izumi discussed the reasons which led his firm to the development of the so-called circular design for a psychiatric hospital. This design was aimed to fulfill the principal of "sociopetality," that is, of encouraging, fostering and—in some cases—forcing the development of stable interpersonal relationships between hospital patients through use of small groups who can meet face-to-face, yet have the privacy of a retreat. (See MENTAL HOSPITALS, April, 1957)

Mr. Izumi remarked that this round plan was offered as only one of a number of possible solutions to the problem of satisfactory structural design, and that it was up to the psychiatrists to indicate its failings and advantages.

The Ohio Team

The second reporting team, from the State of Ohio, included Dr. Robert A. Haines, Director of the Department of Mental Hygiene and Corrections; Dr. James M. Cunningham, Director and Superintendent of the Dayton Children's Psychiatric Hospital; and Mr. Walter Cordes, architect for the Longview State Hospital's reception and treatment center.

Dr. Haines reported that Ohio's total physical mental health needs added up to an amount in excess of $100,000,000. Its long range building program was developed, after an A.P.A. hospital inspection and survey of total needs and resources, not as a static plan but one to be re-evaluated according to progress in research and the findings of studies and similar projects in other states.

The considerations going into the planning of a new psychiatric hospital—one still under construction—were discussed by Dr. James Cunningham. Certain factors played important roles in the design of the Dayton Children's Psychiatric Hospital. First the site, on rolling land, called for construction of a long split-level structure. The site itself had been determined by another factor—that of its availability for use and its accessibility to public trans-

Reception and Treatment Center, Longview State Hospital, Cincinnati, Ohio

portation. The third factor was the multi-function character of the hospital, which was intended for both residential patients and day patients, plus a clinic, and facilities for teaching of professional people.

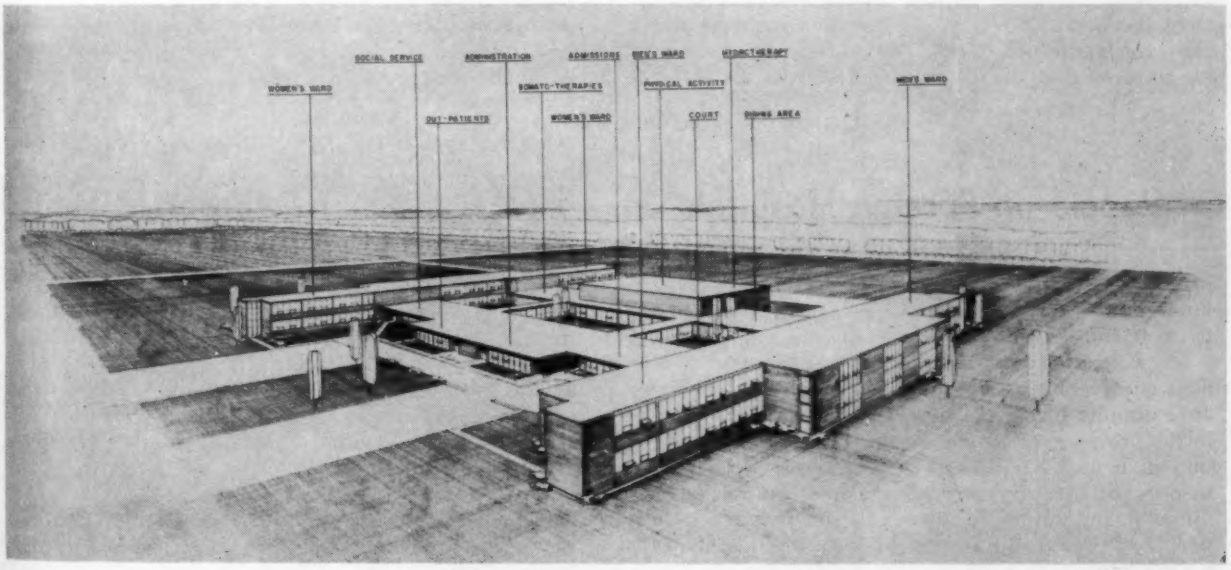
One of the features of the hospital is a closed-circuit television set-up for the use of visual teaching and group instruction. The TV circuits have outlets in interviewing offices, schoolrooms and occupational therapy rooms, as well as in the gymnasium, swimming pool area and the auditorium, so that most of the areas of the hospital are accessible for TV viewing.

Designed for intensive treatment, the hospital is equipped to care for an average of 100 inpatients, with its various facilities handling up to approximately 750 new cases a year.

Another type of hospital design was described by Mr. Walter Cordes, this time from the architect's point of view. The plan for Longview State Hospital's reception and treatment center, he said, was based on a list of requirements obtained, first, through a study of all the written material available from the A.P.A., and secondly, by on-the-job conferences with doctors, nurses, social workers, maintenance and custodial personnel. When conflicts arose, as they inevitably did, they were brought to the level of the Department of Mental Hygiene and resolved there.

The Longview center has been described as an "open-door" hospital; that is, the problem of security is met not at the exterior perimeter of the hospital buildings but on the boundaries of the extensive grounds. The 100 patients of the hospital are divided into 25-person units, and live in one-, two- and four-bed rooms. The male and female members may be brought together, or separated, as determined by the staff of the hospital. A characteristic of the center is the location of the wings extending out from a central core, or axis, somewhat in the order of spokes on a wheel. This design makes possible greater use of outside light and more open exposures.

Teamwork in Indianapolis



The proposed intensive treatment unit at Central State Hospital, Indianapolis, represents another example of psychiatrist-architect coordination. Dr. C. L. Williams, Superintendent of the hospital, outlined the program that preceded the designs, and noted the factors which significantly affect efforts to improve on the past. Such factors include the current high cost of building, and the presence of existing structures, outmoded but massively built, which legislators have to be convinced should be replaced.

He reviewed the changing therapeutic program of the past twenty years, and posed the problem facing administrators—that of determining what facilities and treatment will be in use a decade from now. He presented still another problem, how to provide building security in an unobtrusive manner, and the effort to establish flexibility in security to meet changing needs.

Mr. John Fleck, A.I.A., described his efforts to make "function determine structure" in the Indianapolis hospital design. Faced with the requirement of designing a 200-patient unit in a fairly limited area, he came up with a facility that includes one-floor front and back sections and a pair of two-story wings, with glassed corridors looking out on a three-section courtyard. The courtyard will be landscaped, and its maintenance will be part of the occupational therapy program.

Provisions were made for single and two-bed rooms because they would not be able—at some future date—to accommodate any increase in the number of beds, a measure to ward off the threat of over-crowding.

The Delaware Team

A brief report on the new 175-bed acute convalescent unit at the Delaware State Hospital, Farnhurst, was given by Mr. Alexis Tarumianz, Business Administrator, and Mr. Joseph Carbonell, Architect. Built at a total development cost of $1,575,000, it is a one-story structure which has three landscaped courts. The center court, to be used for guests of the patients, can be seen from the entrance and affords an open view. A music room and occupational therapy room face the landscaped area.

A central section of the hospital facility houses a multi-purpose room which can be used as an auditorium, gymnasium or conference room. The wards are divided into one, two and four-bed rooms. The sum of $100,000 has been allocated for furniture.

Report on Foreign Hospitals

Mr. Guttersen's illustrated report of his tour covered psychiatric hospital facilities in the Netherlands, Switzerland, England, Denmark, Sweden, Italy, India, Thailand, Japan, the Philippines and Hawaii.

Mr. Guttersen was impressed by the amount of freedom enjoyed by patients in widely different countries. In a number of nations he noted a recent development in the provision of separate open cottages for the admission of neurotic patients. These cottages are generally used by patients who enter voluntarily without legal commitment, and were begun as an experiment to reach those people who were reluctant to submit to the stigma of the mental hospital proper.

He noted also that in many existing large hospital facilities there was a trend to divide the buildings into separate complete, smaller hospitals, each having its separate receiving service and staff. Both in the new and existing facilities there was in effect a trend to the small psychiatric hospital.

In foreign countries there has been an increasing use of "activity therapy", together with increasing responsibility placed on the patient, Mr. Guttersen said, with the result that a large number of patients were trusted to live in unlocked buildings without costly safety and security provisions.

The trend to the open door hospital was noted not only in Holland and England, but in Switzerland, the Scandinavian countries and in Japan.

Interior Decoration

The Clinic concluded with a report by hospital furniture consultant Colin McLean. We have now reached the stage where we should coordinate color and design with structure and equipment, he said. The designer, however, to do a satisfactory job, has to know the psychiatrist's thinking on the patient's psycho-social needs and on such matters as security and safety requirements.

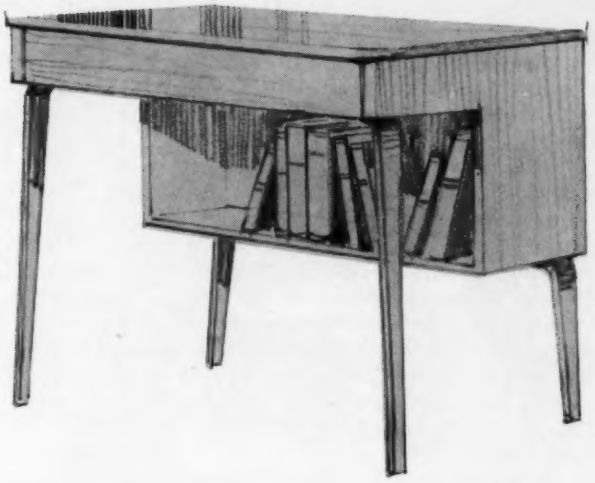
Realizing the emotional effect of color on normal patients, he suggested that color would have a similar but even greater effect on mental patients. Among the trends he suggested as deserving the hospital administrator's attention are the use of drapes or valances for window decoration—to which safety and security features could be added if necessary; the use of carpets in lobbies and corridors as a home-like feature (and a help in keeping the floors on upper levels cleaner); the installation of colored lighting and picture galleries for corridors; and the use of more attractive furniture.

There is no need to buy stock furniture to save money. If you need, say, 100 or more items of a particular piece, it is worth the trouble to have the manufacturer design a special item to suit your needs.

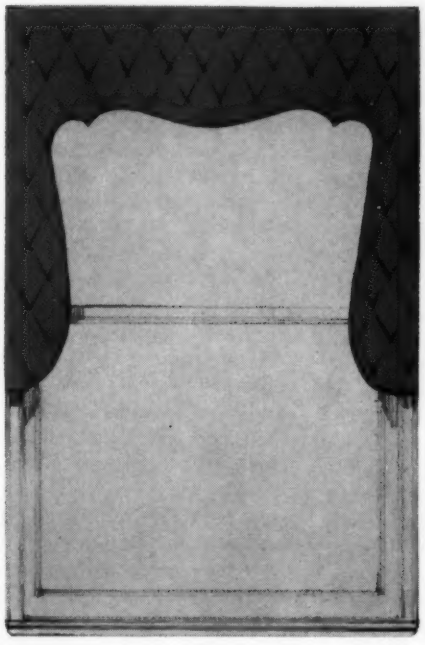
When you look at the mental hospital as a club—a club—which it really is, Mr. McLean said, you start getting away from the depressing idea of a jail or asylum and you come nearer to the goal of a functional shelter for the psychiatric patient, a warm, home-like place that offers hope for the future.

Designs for Space Saving

Two new furniture designs and a window treatment created by Colin McLean

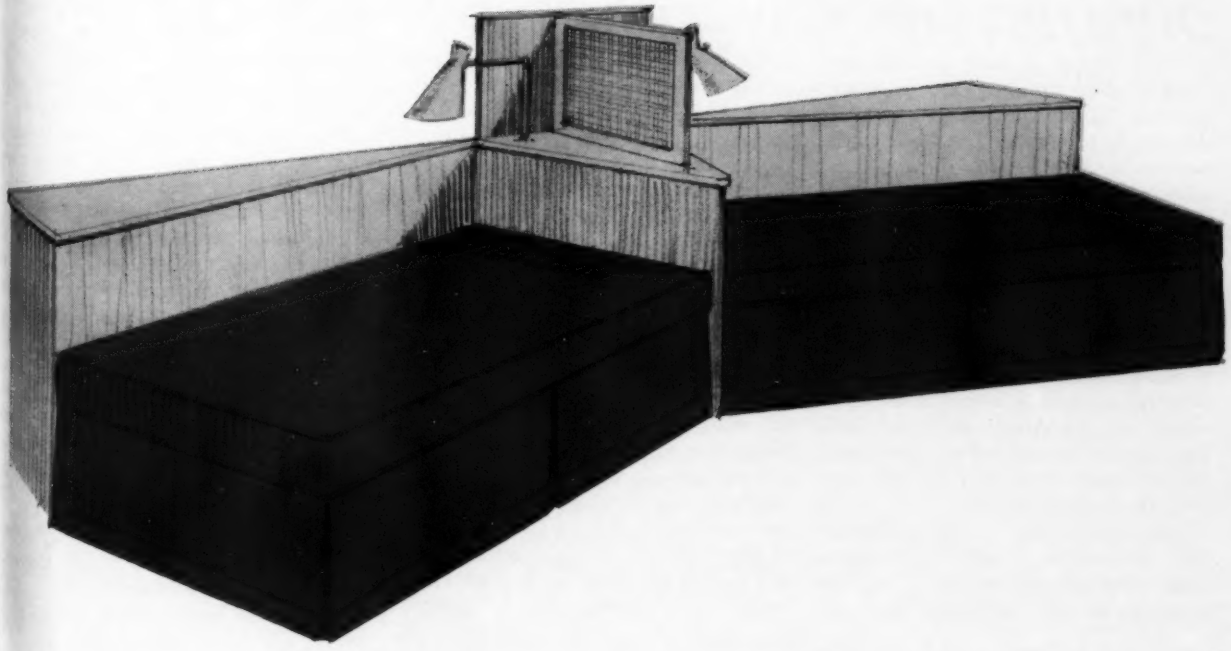


Combination desk with drawer and bookcase saves space in a cramped area and gives shelf and work space



A simple cornice of plywood covered with vinyl drapery decorates a window where draperies are not feasible

Where wall-space is inadequate, a single 8-foot headboard with divider gives privacy and creates useful daytime couches in a two-bed room



Book Review

REPORT OF THE ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS. 1954-57. London. Her Majesty's Stationery Office. Price 10/6 or $1.75. Paper. 328 pp.

"Elizabeth the Second, by the Grace of God, of the United Kingdom . . . Queen, to our right, trusty and well-beloved counsellor, Eustace Sutherland Campbell, Baron Percy of Newcastle: Greeting! Whereas we have deemed it expedient that a Commission should forthwith issue to inquire into the existing law governing the certification and care of persons who are alleged to be suffering from mental illness . . ."

So begins the royal warrant setting up a British commission on mental health legislation. After three years of labor, the Commission has issued this 328-page report.

They start with the assumption that disorders of the mind are illnesses which need medical treatment. They refuse to draw a sharp line between mental illness and mental defect, using the phrase "mental illness" to cover all psychiatric disorders—and not, as we do on this side of the Atlantic, to identify only the psychoses. They prefer the phrase "unsound mind" for the psychoses. The Commission suggests that mental hospitals accept all kinds of psychiatric cases—or at least that there be no advance legal barrier to sending a defective to a mental hospital, or a psychopath to a training school.

They suggest a kind of "negative consent" rule for accepting voluntary patients. In most British, as in most American hospitals, a voluntary patient is denied admission unless he affirmatively says he wants to come in. The Commission points out that no such rigid rule applies to the entry of the physically sick to general hospitals. They urge that mental hospitals accept on a voluntary basis any mentally ill patient brought in who does not actually resist admission. This rule of negative consent is a simple one that would, in the Americas, appreciably increase the ratio of voluntary to committed cases, and decrease the red tape of hospital entry.

They think that a responsible relative should be permitted to take a committed patient out of a hospital even against the advice of the staff, unless there is clear danger. Furthermore, they recommend the organization of medical tribunals (not courts), to which the relative can readily appeal if the hospital officials are intransigent. They suggest a battery of mental health review boards, not only for hearing relatives, but for giving any patient, at stated intervals, an appeal or review. This idea of a sort of supreme court of psychiatry is a brand-new one to this reviewer, and has some challenging implications. Regular annual reviews by outside skilled tribunals might prevent the tragedy of the forgotten patient.

In Britain as here, senile patients are taking an increasing proportion of mental hospital beds. The Commission suggests the development of residential homes for the aged, or geriatric annexes to mental hospitals, to lighten the case load in the fully equipped psychiatric institution. Even now, they think, authorities could look twice at applications for the commitment of harmless and helpless seniles—patients whose needs could be met just as well at homes for the aged, or even in their own homes with a little visiting nurse assistance.

Hospital Should Not Be an Alternative to Prison

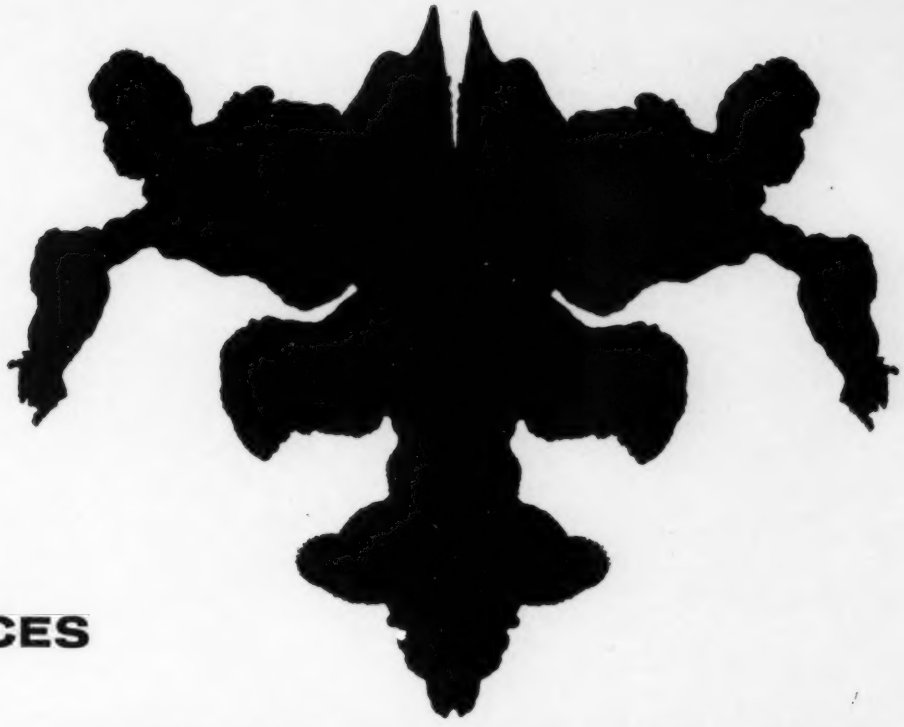
They point out that under present practice, certain forms of behavior are grounds for segregation from society, and that in effect we are creating a new criminal offense. For example, homosexual behavior has been defined as criminal behavior. It falls halfway between ordinary criminal behavior and ordinary mental disorder. They think that commitment to a mental hospital should be restricted to people who have a recognizable psychosis or mental deficiency, that it should not be used as an alternative to prisons; nor should the kind of behavior itself be used to prove that the patient has the disease. Or, to put it another way: "The use of compulsion must be based on a medical diagnosis of the patient's mental condition and not just on his behavior. The difficulty is that with patients in the psychopathic group, it is their behavior which provides the evidence of a mental condition".

When a patient can be committed because he is a psychopath, although he has neither violated the law nor is suffering from any known psychosis, it results in the peculiar situation where persons who are not subject to criminal law are subject to compulsory detention in a hospital because of a diagnosis, which in turn is based on the record of this non-criminal behavior. They say that once a psychopath is forced against his will into a hospital environment and then treated there like a human being, he often accepts with grudging indifference the restrictions of hospitalization, rather than run into the uncertainties of life outside and the chance of being arrested and imprisoned.

In most American jurisdictions, a committed patient is not necessarily considered incompetent. Usually it takes a separate judicial process to brand a patient as incompetent to handle his business affairs. Apparently the British practice is to equate commitment with incompetence, and the Commission suggests that the American rule is the better one. They urge that certified patients be presumed competent unless specifically adjudged otherwise.

The Commission points out that hospitalization for mental illness is not an isolated in-and-out affair, like hospitalization for an appendectomy; patient in, appendix out, case forever finished. Rather, as they see it, the care of emotional illness is a long continuum, of which the hospitalization is only one phase—sometimes only a short or minor phase. The total care program would thus include pre-hospital study and post-hospital rehabilitation. Such part-time hospital activities as the day hospital, the open-ward hospital, and the night hospital are seen as halfway houses on this long road of overall social planning. They are thoroughly convinced that the hospital is not an island in the mainstream of life, but rather an organic part of total living. To which, I suppose, most American psychiatrists would say a firm "Amen".

HENRY A. DAVIDSON, M.D.
Superintendent, Essex County Overbrook Hospital,
Cedar Grove, N. J.



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Clinical excerpts

No. **3** *of a series*

Use of meprobamate in chronic psychiatric patients

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Reduction of anxiety and tension	Number of Patients on meprobamate	on placebo
Marked	5	2
Moderate	8	1
Mild	8	6
No change	9	20
Worse	2	2
	32	31

*"REFERENCE: Tucker, K. and Wilensky, H.: A clinical evaluation of meprobamate therapy in a chronic schizophrenic population. Am. J. Psychiat. 113:698, Feb. 1957.

***Miltown** "is clearly of value in reducing the anxiety and tension level of chronic schizophrenic patients." In a group of 32 patients receiving the drug for 12 weeks (up to 1200 mg. q.i.d.), 41 per cent "showed a significant improvement . . ." Only 10 per cent of patients significantly improved when they received placebo as double-blind controls.**

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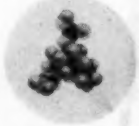

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- alleviates anxiety in chronic psychiatric patients
- facilitates psychotherapeutic rapport
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